STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL068021	A. BUILDING 01 B. WING	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carol Woods Retirement Community -1	750 Weaver Dairy Road Chapel Hill, NC 27514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 delayed egress gate on the courtyard next to Building 7 was not maintained operable. Findings include: a) The delayed egress gate in the courtyard next to building 7 did not initiate an uninterruptable 15 second timing sequence when the gate was pushed to exit. NOTE: Maintenance immediately replaced a defective switch on the latch and restored the gate to proper operation. 2. Based on observation, the main exit door does not have a working manual override switch for the magnetic lock. Findings include: The main exit door which is equipped with special locking has a keyed manual override switch to manually release the maglock that does not work.	C 189	CONSTRUCTION SECTION OCT 05 2015 RECEIVED a. Corrective Action: Corrected during inspection as noted. b. Identify other areas: All other gates have been tested and found in working order. c. Measures in place to ensure no reoccurrence: Preventive Maintenance program already in place d. Corrective action monitored: Manager will conduct follow-up quality assurance checks behind maintenance staff to ensure proper PM outcomes. a. Manual override switch will be installed as indicated b. There are no other doors of this type. This special locking system as installed at original construction in 2002 and has been this way since that time. c. This switch has been added to existing PM program. d. We will work with designers of future installations to comply with applicable codes.	9/11/2015 10/26/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ACH Administrator	10/6/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL068021	A. BUILDING 01 B. WING	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carol Woods Retirement Community -1	750 Weaver Dairy Road Chapel Hill, NC 27514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 189	3. Based on observation, the building was not maintained in a safe manner by not maintaining the fire resistance rating of building components. This would affect all residents by not containing smoke and fire in the room or smoke compartment of origin. Findings include: a. The attic smoke barrier wall over the cross corridor doors at room 7102 has unprotected penetrations by cable. b. In the attic next to the smoke barrier wall at room 6102 rated enclosures for the fluorescent fixtures have unprotected penetrations by flex conduit. c. The exterior Hot Water/Mechanical room has unprotected ceiling penetrations by PVC pipe. NOTE: PVC pipe 2 1/2 inches in diameter or largerrequires a "fire collar" or similar system for protection. These unprotected openings are not in conformance with the requirement to use a through penetration fire stop system that has been tested in accordance with ASTM E-814. 4. Based on observation, the building was not maintained in a safe manner by improper storage of oxygen cylinders. This would affect all residents by potentially exposing them to hazards from a ruptured cylinder. Findings include: Oxygen bottles are not secured in a holder in the following locations: a) Room 7103 b) Med Room	C 189	a. Corrective Action: a.) Cable penetration fire stopped. b) fluorescent fixture openings fire stopped. c) ceiling penetration fire stopped. b. Identify other areas: All other similar areas were inspected, and no other fire stop issues were identified. c.) Measures in place to ensure no reoccurrence: This item has been added to existing PM program. d) Corrective action monitored: There is currently a facility safety inspection process in place. This inspection item has been added to the inspection criteria. Item 4: a. Corrective action: On the day of inspection, oxygen cylinder in Room 6103 was moved to oxygen storage racks. b. Identify other areas: We have inspected other areas and found no re-occurrence c. Measures in place to ensure no reoccurrence: Signs have been posted and staff will receive training. d. Corrective action monitored: This item is part of the facility safety inspection process.	9/14/2015 9/11/2015 10/26/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kenneth Ochs Jr	ACH Administrator	10/6/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL068021	A. BUILDING 01 B. WING	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carol Woods Retirement Community -1	750 Weaver Dairy Road Chapel Hill, NC 27514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 189	5. Based on observation, the kitchen appliances were not maintained in a safe manner. Findings include: The stove was not being used in the kitchen, however the switch allowed the burner to be turned on. This was immediately brought to the attention of staff who got the key and locked out the equipment	C 189	a. Corrective Action: This item was completed during inspection. b. Identify other areas: This is the only area of this nature in this building. c. Measures in place to ensure no reoccurrence: Signs have been posted and staff are receiving training to observe and correct these deficiencies as part of their routine job. d. Corrective Action monitored: Item has been added to staff daily check sheet.	9/11/2015 10/26/2015
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; (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, the exhaust ventilation was not provided in required areas: a) Housekeepingroom near Med Room. Verify that this supply vent is exhausting to outside the bldg, or provide exhaust fan in the room.		a. Corrective action: Items 1 and a) all listed room ventilation was inspected and found to exhausted to the outside. b. Identify other areas: All areas were checked. c. Measures in place to ensure no reoccurrence: There are no other areas and no plans for remodeling. Existing equipment will remain unchanged. d. Corrective action monitored for no reoccurrence: Not applicable. Equipment when tested was found to exhaust to the outside.	9/14/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ACH Administrator	10/6/2015