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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

SEP 1 9 2011

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		346506	B. WING 1970 1970				/2011	
	OVIDER OR SUPPLIER ONE A MASONIC AN	ED EASTERN STAR COMMUNITY		71	EET ADDRESS, CHY, STATE, ZIP CODE 00 SOUTH HOLDEN ROAD BREENBBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X6) COMPLETION DATE	
F 371 SS≃D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions		F	371	This plan of correction is required by State and Feder provider maintains that deficiencies do not indicollectively jeopardize the head of the residents, nor are character so as to limit to capacity to render adequate cat	al law. The the alleged ividually or ith and safety they of such he providers'		
LABORATOR	This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility falled to maintain sanitary conditions in the kitchen by failing to keep food preparation equipment (the convection oven, five steam table pans, the lowerator, the ice machine, the cooks reach in, double oven door handles and a preparation table shelf) cleaned to destroy potential disease carrying organisms and to prevent the harboring of pests and insects. The findings include: During the initial kitchen tour on 8/30/11 at 9:50 AM the convection oven which is used for baking and roasting was observed to have four white dried food particles approximately ½ inch in diameter and multiple black spots of burnt food particles on the bottom of the oven. The front ledge of the convection oven was observed to have a black build up of sticky substance located inside the open oven door ledge. During an observation of the kitchen on 8/31/11 at 10:16 AM five of six full size steam table pans		### Park		1. Items identified during inspection were corrected in the Kitchen Manager and Dietary Services. 2. A new sanitation checklisty by the Director of Dietary Sfull inspection done to ensure meets sanitation requirements. 3. Directed inservice training cleaning schedules, and also and storing of equipmen conducted by the Director Services with all Dietary empleted weekly for 3 mont monthly going forward as ongoing Quality Assurance either the Director of Dietary Kitchen Manager. Completion date: September 2	mediately by Director of Was developed ervices and a entire kitchen on sanitation, proper drying thas been of Dietary oyees. ection will be his and at least part of our program by Services or the	9/23/2011	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excussed from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

If continuation sheet Page 1 of 3

40MINISTRATOR

Facility ID: 923331

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345506	B. WING			09/01/2011	
- *- * * * * *	ROVIDER OR SUPPLIER ONE A MASONIC AND	EASTERN STAR COMMUNITY		700 :	T ADDRESS, CITY, STAYE, 2IP CODE SOUTH HOLDEN ROAD SENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	IOULD BE	(X6) COMPLETION DATE
F 371	During a second of AM the lowerator of observed with a 3 i food particle smear. On the narrow side of a milky substance inches long were of reach in located to observed to have a food particles. The machine was observed drip of a red at the door of the leapproximately three of the ice machine, observed to be in the total particles and food many observed to be in the convection ow and roasting was observed to he crumbs and food many observed to he crumbs and food particles on the boledge of the convehave a black build inside the open ov behind the tray line 3 inch yellow greet front side of lowers.	ge 1 ed wet for service. pservation on 8/31/11 at 11:05 potated behind the tray line was not by 3 inch yellow green on the front side of lowerator, of the lowerator six dried drips the approximately four to eight beserved. The top of the cooks the left of the lowerator was thin film of dust and dried front right side of the ice red to have a 3 inch wide color substance which began the machine and ran the feet down towards the base The convection oven was the same condition. Ition of the kitchen on 9/01/11 tible oven doors were observed bovering both handles. A bocated near the kitchen office ave a heavy layer of food esidue stored on the middle shes were stored for service. en which is used for baking boserved to have four white a approximately ½ inch in ple black spots of burnt food tiom of the oven. The front ction oven was observed to up of sticky substance located en door. The lowerator located en was observed with a 3 inch by in food particle smear on the drips of a milky substance	L.	371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLE	
		345506	В. WING		09/	01/2011
	ROVIDER OR SUPPLIER ONE A MASONIC AND I	EASTERN STAR COMMUNITY	700	et address, city, state, zip co south holden road Eensboro, nc 27407	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROMDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
F 371	observed. The top of to the left of the lowe a thin film of dust and front right side of the to have a 3 inch wide substance which beg machine and ran app to the base of the ice. In an interview with the 9/01/11 at 9:55 AM, it these areas to my ull schedule. I would explown. We had an in-	eight inches long were the cooks reach in located rator was observed to have i dried food particles. The ice machine was observed dried drip of a red color an at the door of the ice roximately three feet down	F 371			

BEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN IND PLAN (T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE S COMPLI	URVEY ETED
	ROVIDER OR SUPPLIER	345506 ND EASTERN STAR COMMUNITY	STRE 700	ET ADDRESS, CITY, STATE, ZIP COL D SOUTH HOLDEN ROAD REENSBORO, NC 27407		7/2011
(X4) IP PREFIX TAG	(EACH DEFICIENC)	YEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X6) COMPLETI DATE
K 012 SS=F	Building construction	on type and height meets one 0.1.6.2, 19.1.6.3, 19.1.6.4,	K 012	Tag K 012 The scams (expansion joints the ceiling in the identified owill be repaired by 11/10/11 The lead mechanic will checcelling scams (expansion joints)	rtens . · ·k all	11/10/11
K 029 SS=F	Based on observate between 9:00 AM a noted: 1) Throughout the foliation in the ceiling assembly we maintained in good 42 CFR 483.70(a)	s not met as evidenced by: ilon on Friday 7/10/2011 and 1:00 PM the following was acility the seams (expansion that is part of the one hour ere not secured and condition. FETY CODE STANDARD	K 029	in the nursing center to ensure are seenre by 10/21/11. Ali ceiling seams (expansion joints) will be repaired and secured by 11/10/11. The Lead mechanic will more the condition of the ceiling s (expansion joints in the her center quarterly thru our Quarterly thru our Quarterly these are clean.	re all i nitor cams ith ality	
	fire-rated doors) or extinguishing system and/or 19.3.5.4 profite approved automoption is used, the other spaces by sm doors. Doors are sifield-applied protect	construction (with % hour an approved automatic fire in in accordance with 8.4.1 lects hazardous areas. When hatic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or live plates that do not exceed bottom of the door are		Self closing devices have been installed on the facility service storage room, the storage closin the clinic area, equipment storage closet #50 corridor, a the activity room storage close corridor door. The lead mechanic has check all storage areas of the mursin facility to ensure all other sto areas are equipped with the required solf closing devices.	ce sul and wt	10/21/11 -
	Based on observati	s not met as evidenced by; lon on Friday 7/10/2011. nd 1:00 PM the following was	us annualing colony of security annual security security	The lead mechanic will monit these door closures quarterly our Quality Assurance prograte compliance.	with .	

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is notermined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosuble 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 disclosuble 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER: 345506		A. BUILDING 01 - MAIN BUILDING 01		01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		B, WI	10		10/0	7/2011
PROVIDER OR SUPPLIER TONE A MASONIC A	ND EASTERN STAR COMMUNITY	,	700	SOUTH HOLDEN ROAD		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SI	IOUI.D BE	(X6) COMPLETION DATE
Continued From page 1 1) The facility service storage room corridor (77A) was not self closing. 2) The storage closet in the clinic area was not equipped with a self closing device. 3) Equipment storage closet # 50 corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device (Located next to soiled linen room #71) 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1		K 029		Tag K 038 Staff training will be done by the Administrator and Director of Nursing to educate on the location and function of the		11/10/11
Based on observal between 9:00 AM a noted: 1) Staff members we nurse station and infamiliar with the manage lock doors in the 42 CFR 483.70(a) NFPA 101 LIFE SA A fire alarm system installed, tested, and with NFPA 70 Nation 72. The system has and testing program	tion on Friday 7/10/2011 and 1:00 PM the following was then questioned at the Rose the Dementia unit was not ester override switches for the he facility. FETY CODE STANDARD required for life safety is d maintained in accordance and Electrical Code and NFPA an approved maintenance in complying with applicable	K ()52	added by our Staff Developme Coordinator to our orientation new employees. Quarterly monitoring of staff knowledge will be done by our	nt for	
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER TONE A MASONIC A SUMMARY STY (EACH DEFICIENCY REGULATORY OR IN 1) The facility serving was not self closing equipped with a self and equipped with a self closing and the self equipped with a self continued From particular serving was not equipped with a self equipped	This STANDARD is not met as evidenced by: Based on observation on Friday 7/10/2011 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 7/10/2011 Exit access is arranged so that exits are readily accessible at all times in accordance with he master override switches for the mag lock doors in the permettia unit was not applied with a self closing device.	TOF DEFICIENCIES DE CORRECTION (X1) PROVIDER/SUPPLIER/VICTION NUMBER: 345508 PROVIDER OR SUPPLIER TONE A MASONIC AND EASTERN STAR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 1) The facility service storage room corridor (77A) was not self closing. 2) The storage closet in the clinic area was not equipped with a self closing device. 3) Equipment storage closet # 50 corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. 4) The activity room storage close troridor door was not equipped with a self closing device. (Located next to soiled linen room #71) 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 7/10/2011 between 9:00 AM and 1:00 PM the following was noted: 1) Staff members when questioned at the Rose nurse station and in the Dementia unit was not familiar with the master override switches for the mag lock doors in the facility. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 0 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	TOP DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CATION NUMBER: 345506 PROVIDER OR SUPPLIER TONE A MASONIC AND EASTERN STAR COMMUNITY SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 1) The facility service storage room corridor (77A) was not self closing. 2) The storage closet in the clinic area was not equipped with a self closing device. 3) Equipment storage closet # 50 corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. 1) Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 7/10/2011 between 9:00 AM and 1:00 PM the following was noted: 1) Staff members when questioned at the Rose nurse station and in the Dementia unit was not familiar with the master override switches for the mag lock doors in the facility. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	TOP DEFICENCIES OF CORRECTION (X1) PROVIDER SUPPLIER 345506 ROVIDER OR SUPPLIER TONE A MASONIC AND EASTERN STAR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY) MIST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 1) The facility service storage room corridor (77A) was not self closing. 2) The storage close of the clinic area was not equipped with a self closing device. 4) The activity room storage closet corridor door was not equipped with a self closing device. (Located next to soiled linen room #71) 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD This STANDARD is not met as evidenced by: Based on observation on Friday 7/10/2011 between 9:00 AM and 1:00 PM the following was noted: 1) Staff members when questioned at the Rose nurse station and in the Dementia unit was not familiar with the master overrido switches for tho mag lock doors in the facility. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD This STANDARD is not met as evidenced by: Based on observation on Friday 7/10/2011 between 9:00 AM and 1:00 PM the following was noted: 1) Staff members when questioned at the Rose nurse station and in the Dementia unit was not familiar with the master overrido switches for tho mag lock doors in the facility. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	TO PERCEIRENCES PROVIDER CONTRECTION A SULLIPLE CONSTRUCTION 345508 STREET ADDRESS, CITY, STATE, ZIP CODE TONE A MASONIC AND EASTERN STAR COMMUNITY SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PIRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 1 1) The facility service storage room corridor (77A) was not self closing device. 2) The storage closed in the clinic area was not equilipped with a self closing device. 4) The actify room storage closed corridor door was not equilipped with a self closing device. 4) The actify room storage closed or circler of or was not equilipped with a self closing device. 4) The actify room storage closed or independent storage closed or independent storage closed in the clinic area was not equilipped with a self closing device. 4) The actify room storage closed or independent storage closed in the clinic area was not equilipped with a self closing device. 4) The actify room storage closed in the clinic area was not equilipped with a self closing device. 4) The actify room storage closed in the clinic area was not equilipped with a self closing device. 4) The actify room storage closed or independent storage closed or independent storage closed in the clinic area was not equilipped with a self closing device. 4) The actify room storage closed in the clinic area was not equilipped with a self closing device. 5) Exit access is arranged so that exits are readily accessible at all times in accordance with section of Nursing to close on the Administrator and Director of Nursing to education

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SI IRPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 10/07/2011	
	345506			OT - MAIN DOLLANOVI.		
	PROVIDER OR SUPPLIER TONE A MASONIC A	ND EASTERN STAR COMMUNIT	v '	REET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 052		ige 2 s not met as evidenced by:	K 052	The visual notification devices for the fire alarm system in the Dementia Unit have been repaired (10/19/11). All visual notification devices f the fire alarm system in the nursing facility have been checked by an outside contractor.	or .	10/21/11
·K 067 SS≃D	Based on observal between 9:00 AM a noted: 1) The visual notific system in the Deme when testing the fire 42 CFR 483.70(a) NFPA 101 LIFE SA Heating, ventilating with the provisions on accordance with	tion on Friday 7/10/2011 and 1:00 PM the following was ration devices for the fire alarm rentia Unit did not operate a alarm system. FETY CODE STANDARD and air conditioning comply of section 9.2 and are installed the manufacturer's	K 067	Tag K 067 The smoke duct detector located in the HVAC unit in the Attle or	on r	10/19/11
K 144 SS=F	This STANDARD is Based on observat between 9:00 AM anoted: 1) The smoke duct unit in the Attic on 4 maintained in good 42 CFR 483.70(a)	s not met as evidenced by: ion on Friday 7/10/2011 nd 1:00 PM the following was detector located in the HVAC 00 hall was not clean and condition)	K 144	400 hall had been cleaned. (10/19/11) All of the smoke duct detectors the attic were inspected and cleaned by the lead mechanic. (10/19/11) This will be monitored quarterly in conjunction with our Quality Assurance program by the lead mechanic.	in	
00-j [*]	Generators are insp	ected weekly and exercised				
ON AND AR	97/09 00\ Description \/sectores	51				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OCIVICIO PON MEDICARE & MEDICAID SERVICES					OMB NO, 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
.,,.		345506	B, WII	NG		10/0	07/2011
WHITES	T	ND EASTERN STAR COMMUNIT	Y	700 8	TADDRESS, CITY, STATE, ZIP CODE BOUTH HOLDEN ROAD ENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 144	Continued From pa under load for 30 m accordance with NF	inutes per month in	K.	144	Tag K 144 1) The documentation for the monthly load test for the generator will include the percente loaded and the temperature rise. (10/31/11) The lead mechanic will audit the documentation for the monthly generator tests and monitor that the quality assurance process.	ıc	11/15/[]
	Based on observation between 9:00 AM an noted: 1) Documentation for conducted without retemperature rise. A completed within the NFPA 110 6-4.2.2 (TEPS installations the requirements of 6-4, with the available Effannually with supple nameplate rating for percent of nameplate followed by 75 percent of nameplate followed by 75 percent of the testing) 2) The emergency of within 10 seconds	1999 edition) Diesel-powered			A load bank test will be completed per regulation by November 15, 2011. This test will be done annually part of our preventative maintenance program and monitored by the lead mechanic thru our quality assurance program to ensure compliance. 2) The transfer switch will be replaced with a new switch, Monthly generator tests will not be done by flipping the electrical breaker and forcing a test of the transfer switches along with the generator. The lead mechanic will monitor these tests monthly thru our quality assurance program.	C	10/31/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESIGNATION AND PROMPERSON AND P

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE S COMPL	BURVEY ETED
		345506	B. WING		10/0	07/2011
	PROVIDER OR SUPPLIER TONE A MASONIC A	ND EASTERN STAR COMMUNIT	Y 70	EET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH HOLDEN ROAD REENSBORO, NC 27407	.1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE:
K 144	Continued From pa	ge 4	K 144			
K 147 SS=E		FETY CODE STANDARD	. K 147	Tag K 147		
	Electrical wiring and with NFPA 70, Nati	d equipment is in accordance ional Electrical Code, 9.1.2		 The power strips have been removed from the beauty shop a well as resident rooms 602 and 612. 	as	11/10/11
	Based on observation between 9:00 AM annoted: 1) In resident room shop surge protected.	s not met as evidenced by: ion on Friday 7/10/2011 nd 1:00 PM the following was 602, 612 and in the beauty or/multi outlet power strips use for lights and other		Residents will be reminded by the Administrator at the November Resident Meetings that these types of devices are a permitted and assistance given to remove any other devices found	lo	TOTAL
	equipment, 2) The medication re	efrigeratorin the clinic area to emergency power.		2) Testing was done of the power outlets in the clinic area and one was identified as an emergency outlet. It was not properly labeled with a red cove and this was corrected immediately and the refrigerator plugged into the emergency outlet.		10/19/11