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	(X3) DATE SURVEY COMPLETED
	345533	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

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 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.

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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	(X3) DATE SURVEY COMPLETED
	345533	A. BUILDING 01 - THE CEDARS OF CHAPEl B. WING ________	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

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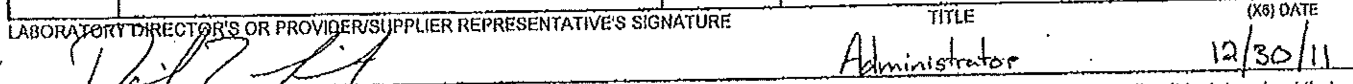
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) The window in the Wellness Clinic that open into the exit corridor does not close smoke tight. 42 CFR 483.70	K 017	**K 017** **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?** No actual harm resulted from this practice. The window in the Wellness Clinic will be modified to include side trim and center sweep to maintain appropriate smoke barrier. **II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?** This practice had the potential to affect all Members. Corrective action is mentioned above. **III. What measures will be put in place to ensure the practice does not recur?** Inspection of sliding glass windows will be added as part of the routine preventative maintenance checks which occur on a monthly basis. See Exhibit D. **IV. How will the corrective action be monitored?** Director of Plant Services to review the PM checks once they are completed and perform on-going spot checks of sliding glass windows.	1/16/12
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) The corridor door to resident room 31 did not close smoke tight. 2) The corridor door to the dinning room next to	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE



Administrator — 12/30/11

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 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.

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	345533	A. BUILDING 01 - THE CEDARS OF CHAPEI B. WING ______	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

(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) COMPLETION DATE
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) The window in the Wellness Clinic that open into the exit corridor does not close smoke tight. 42 CFR 483.70	K 017	**K 018** **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?** No actual harm resulted from this practice. The door for resident room 31 was adjusted and repaired to close properly on 12/15/11. See Exhibit A. Install center astragal on corridor doors by resident room 12. Additionally, all corridor doors will be inspected and modified accordingly to ensure they resist the passage of smoke. **II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?**	1/16/12
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) The corridor door to resident room 31 did not close smoke tight. 2) The corridor door to the dinning room next to	K 018	This practice had the potential to affect all Members. Corrective action is mentioned above. **III. What measures will be put in place to ensure the practice does not recur?** Inspection of resident room doors and corridor doors is part of the routine preventative maintenance checks which occur on a monthly and quarterly basis respectively. Adjustments will be made as needed. See Exhibits B and C. **IV. How will the corrective action be monitored?** Director of Plant Services to review the PM checks once they are completed and perform on-going spot checks of resident room doors and corridor doors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	345533	A. BUILDING 01 - THE CEDARS OF CHAPEI B. WING	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

(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) COMPLETION DATE
K 018	Continued From page 1 resident room 12 did not close smoke tight. 42 CFR 483.70	K 018	**K 054** **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?** No actual harm resulted from this practice. The smoke duct detectors in the attic area will be cleaned and in good condition by the fire alarm vendor. Additionally, all smoke duct detectors in the attic will be inspected and cleaned, if necessary.	1/16/12
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) The smoke wall located in the attic area between North and South unit has holes and penetrations in the wall that were not sealed in order to maintain the required rating of the wall. 42 CFR 483.70	K 025	**II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?** This practice had the potential to affect all Members. Corrective action is mentioned above. **III. What measures will be put in place to ensure the practice does not recur?** Fire alarm vendor will begin inspecting and cleaning the sampling tube for the smoke duct detectors as part of the required annual inspection.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054	**IV. How will the corrective action be monitored?** Director of Plant Services will review the results of the required annual inspection. Additionally, a visual inspection by facility staff will be completed once the vendor has completed their service. See Exhibit F.	

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	345533	A. BUILDING 01 - THE CEDARS OF CHAPEl B. WING ______	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

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K 054	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) The smoke duct detectors in the attic area located in the HVAC units were not clean and maintained in good condition. 42 CFR 483.70	K 054	K 056 **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?** -No actual harm resulted from this practice. -Inspection of all sprinkler heads in the SNF indicate that intermediate sprinkler heads are used when within 12-24 inches of a hot air diffuser. NFPA 13 (Table 8.3.2.5(c)) indicates that intermediate-temperature sprinkles are appropriate 12-24 inches from a hot air diffuser (Exhibit M). The Cedars has contacted the NC Office of the State Fire Marshal for guidance on NFPA 13 and the use of intermediate sprinkler heads. Additionally, The Cedars has asked the general contractor of the construction as well as the contractor who installed the sprinklers to determine why GREEN sprinkler heads where use (i.e. directive from fire marshal, Town of Chapel Hill, etc.) -Once a determination has been made, The Cedars will change all necessary sprinkler heads to be in compliance with NFPA 13. **II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?** This practice had the potential to affect all Members. Corrective action is mentioned above. **III. What measures will be put in place to ensure the practice does not recur?** Once a determination has been made, sprinkler heads will be changed as necessary and no further measures will need to be taken. **IV. How will the corrective action be monitored?** Once all necessary sprinkler heads have been changed, the Director of Plant Services will audit all sprinkler heads to verify appropriate heads were used	1/16/12
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) Throughout the facility there are sprinkler heads in the facility rated for Intermediate Temperature Classification, Glass Bulb Color of Green temperature rating of (200°F) in place of Ordinary Temperature Classification, Glass Bulb	K 056		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345533	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE CEDARS OF CHAPEI B. WING	(X3) DATE SURVEY COMPLETED 12/13/2011

NAME OF PROVIDER OR SUPPLIER: THE CEDARS OF CHAPEL HILL

STREET ADDRESS, CITY, STATE, ZIP CODE: 101 GREEN CEDAR LANE, CHAPEL HILL, NC 27517

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K 056	Continued From page 3 Color of Red (155°F). 42 CFR 483.70	K 056	**K 067** **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?**	1/16/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) One of three HVAC units containing smoke dampers located in the attic between North and South Unit was not provided with an access door that would allow for inspection and maintenance. 2) HVAC unit 5 for the kitchen did not shut down upon activation on the fire alarm. 42 CFR 483.70	K 067	No actual harm resulted from this practice. The access door for the smoke damper for the referenced duct was in place but not visible due to being covered by insulation. The insulation was adjusted so access door is accessible and visible. See Exhibit G. Additionally, the remaining smoke damper access locations will be inspected annually to verify accessibility. See Exhibit H. It was determined that the HVAC unit did shut down in ALARM status but when the alarm was SILENCED the unit reactivated. The fire alarm system was reprogrammed on 12/16/11 to not reactivate until the alarm has been returned to NORMAL. All other units were programmed to remain off until the alarm has been returned to NORMAL. See Exhibit I. **II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?**	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) Two of the smoke dampers located in the attic between North and South Units did not close upon activation of fire alarm.	K 104	This practice had the potential to affect all Members. Corrective action is mentioned above. **III. What measures will be put in place to ensure the practice does not recur?** The reprogramming of the one unit and verifying the programming of all other units should prevent this practice from recurring. Additionally, the required annual inspection will monitor continued compliance. **IV. How will the corrective action be monitored?** Director of Plant Services will review the results of the required annual inspection and the annual inspection of access locations for the smoke dampers.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

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K 056	Continued From page 3 Color of Red (155°F). 42 CFR 483.70	K 056	**K 104** **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?**	1/16/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) One of three HVAC units containing smoke dampers located in the attic between North and South Unit was not provided with an access door that would allow for inspection and maintenance. 2) HVAC unit 5 for the kitchen did not shut down upon activation on the fire alarm. 42 CFR 483.70	K 067	No actual harm resulted from this practice. On 12/19/11, Lee Air serviced the smoke dampers and they now operate as designed. Battery supported thermostats were linked to the faulty operation of smoke dampers. All thermostats will be inspected and any batter supported thermostats will be replaced. See Exhibit J. **II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?** This practice had the potential to affect all Members. Corrective action is mentioned above.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) Two of the smoke dampers located in the attic between North and South Units did not close upon activation of fire alarm.	K 104	**III. What measures will be put in place to ensure the practice does not recur?** The fire alarm vendor will inspect the smoke dampers as part of the required annual inspection. **IV. How will the corrective action be monitored?** Director of Plant Services will review the results of the required annual inspection.	

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K 104	Continued From page 4 42 CFR 483.70	K 104		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) An annual generator load bank test has not been conducted on the facility. Facility at the time of the survey could not provide documentation indication that an annual load bank is not required. 42 CFR 483.70	K 144	**K 144** **I. What corrective action will be put in place for the resident(s) identified as having been affected by this practice?** No actual harm resulted from this practice. The annual generator load bank test was performed on 11/3/2011 for both generators. See Exhibits K & L. **II. How other residents having the potential to be affected by this practice will be identified and what corrective action will take place?** This practice had the potential to affect all Members. Corrective action is mentioned above. **III. What measures will be put in place to ensure the practice does not recur?** The annual generator load bank tests were completed as necessary and are scheduled yearly to ensure compliance. **IV. How will the corrective action be monitored?** Director of Plant Services will review the results of the required annual inspection.	1/16/12