

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

PRINTED: 01/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345546	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2012
NAME OF PROVIDER OR SUPPLIER THE ROSEWOOD HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615		
(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 No deficiencies resulted from recertification survey dated 1/5/11 Event ID OM6T11.	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.

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


PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345546	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE CYPRESS OF RALEIK B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE ROSEWOOD HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615
--	---

(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 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 1/24/12 at approximately noon the emergency generator was non-compliant, specific findings include the emergency generator failed to crank upon testing.</p>	K 144	<p>K-144</p> <p>The Generator was repaired and tested by Cummins Atlantic on 1/24/12.</p> <p>The existing remote annunciator panel specific to the generator was relocated on 1/25/12 to an area where nursing and maintenance staff can monitor for alarm notifications.</p> <p>The maintenance and nursing staff were In-serviced 1/27/12 on the operation of the panel by the maintenance supervisor.</p> <p>At the time of hire and annually thereafter Nursing and Maintenance staff will receive training on the fire and Generator annunciator panels.</p> <p>Maintenance staff were in-serviced on 1/27/12 on how to properly inspect the charging system by the Director of Facility Services.</p>	1/31/12
---------------	---	-------	---	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/27/12
---	------------------------	----------------------

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.

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

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345546	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE CYPRESS OF RALEIGH B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
NAME OF PROVIDER OR SUPPLIER THE ROSEWOOD HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615	
(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 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 1/24/12 at approximately noon the emergency generator was non-compliant, specific findings include the emergency generator failed to crank upon testing.</p>	K 144	<p>The weekly generator inspection sheet was modified on 1/25/12 to include inspection of the Charging system. Maintenance Staff will Report any generator fail tests to the director of facility services or their designee and corrective actions will occur immediately to repair the malfunction.</p> <p>Weekly times four, then quarterly thereafter the Director of Facility Services will audit the Generator weekly inspection sheets for compliance. Any non-complaint issues identified will be corrected immediately.</p> <p>Monthly times one, then quarterly thereafter the Director of Facility Services will report to the Administrator the results of the weekly generator audits and any non compliant issues.</p> <p>Quarterly times one the Administrator will report to the Rosewood Quality Assessment and Assurance Committee the status of the generator and any non compliant generator issues for their review and comments.</p>	1/31/12

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.

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

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345546	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE CYPRESS OF RALEIC B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE ROSEWOOD HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615
--	---

(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 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 1/24/12 at approximately noon the emergency generator was non-compliant, specific findings include the emergency generator failed to crank upon testing.</p>	K 144	<p>The facility is confident that all corrective actions will be fully implemented by 1/31/12.</p>	1/31/12
---------------	---	-------	--	---------

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.