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

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION  NG	(X3) DATE SI COMPLE	JRVEY ETED
		345546	B. WI	NG.		01/0	5/2012
	ROVIDER OR SUPPLIER	ENTER	•		REET ADDRESS, CITY, STATE, ZIP CODE 8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAC	ΉX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000		sulted from recertification Event ID OM6T11.	F	000			
ADOBATOR	A DIDECTARIO AD DRAVIE	SED/SLIDDLIER REPRESENTATIVE'S SIG	MATURE		TITIE		(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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG 01 - THE CYPRESS OF RALEIC	(X3) DATE SURVEY COMPLETED	
		345546	B. WING		01/24/2012	
	ROVIDER OR SUPPLIER SEWOOD HEALTH CE	ENTER	8	REET ADDRESS, CITY, STATE, ZIP CODE 710 CYPRESS CLUB DRIVE / RALEIGH, NC 27615 / (AA)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 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)	OLD BEC	(X6) COMPLETIO DATE
K 144 SS=F	Generators are Inspunder load for 30 m accordance with NF  This STANDARD is 42 CFR 483.70 By observation on 1 the emergency gen	s not met as evidenced by:  1/24/12 at approximately noon erator was non-compliant, lude the emergency	K 144	K-144  The Generator was repaired tested by Cummins Atlantic 1/24/12.  The existing remote annunci panel specific to the generator relocated on 1/25/12 to an arwhere nursing and maintenance and monitor for alarm notific.  The maintenance and nursing were In-serviced 1/27/12 on operation of the panel by the maintenance supervisor.  At the time of hire and annual thereafter Nursing and Main staff will receive training on and Generator annunciator publication.  Maintenance staff were in-secon 1/27/12 on how to proper inspect the charging system Director of Facility Services.	ator or was ea nce staff cations. g staff the ally tenance the fire anels. erviced	1/31/1
3ORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.

Administrator

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

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ·	(X2) A		IPLE CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED
		345546	B, WI			04/5	4/0040
} -	PROVIDER OR SUPPLIER	L	<b> </b>	STREET ADDRESS, CITY, STATE, ZIP CODE 8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 144 SS≂F		FETY CODE STANDARD pected weekly and exercised inutes per month in FPA 99. 3.4.4.1.	K	144	The weekly generator inspect sheet was modified on 1/25/1 include inspection of the Chasystem. Maintenance Staff we Report any generator fail test director of facility services or designee and corrective action occur immediately to repair the malfunction.	2 to arging vill s to the particular their ns will	
	42 CFR 483.70 By observation on 1	s not met as evidenced by: /24/12 at approximately noon erator was non-compliant, lude the emergency erank upon testing.			Weekly times four, then quar thereafter the Director of Fac- Services will audit the General weekly inspection sheets for compliance. Any non-complissues identified will be corre- immediately.	ility ator aint	/31 <i> 1</i> 2
					Monthly times one, then quare thereafter the Director of Fac Services will report to the Administrator the results of the weekly generator audits and a compliant issues.	ility he	
					Quarterly times one the Administrator will report to to Rosewood Quality Assessments Assurance Committee the state the generator and any non congenerator issues for their revisionments.	ent and etus of mpliant	
ABORATORY	DIRECTOR'S OR OBOVIDE	RISUPPLIER REPRESENTATIVE'S SIGN	LATE INC	$\perp$	ากเล		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0M6T21

Facility ID: 050891

If continuation sheet Page 2 of 13

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

(X1) PROVIDER/SUPPLIER/CLIA

345546

PRINTED: 01/26/2012 FORM APPROVED

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

**IDENTIFICATION NUMBER:** A. BUILDING 01 - THE CYPRESS OF RALEIC

(X2) MULTIPLE CONSTRUCTION

B. WING

01/24/2012

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

THE ROSEWOOD HEALTH CENTER			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)	(X6) COMPLETION DATE		
K 144 SS=F	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.	K 144	The facility is confident that all corrective actions will be fully implemented by 1/31/12.	/31/r <u>2</u>		
	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 falled to crank upon testing.					
***************************************		٠				

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