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

PRINTED: 02/02/20-FORM APPROVE OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED
		345155	B. Wil	√G_		01/0	6/2012
NAME OF P	ROVIDER OR SUPPLIER		-	4	REET ADDRESS, CITY, STATE, ZIP CODE		*****
RANDOL	PH HEALTH AND RE	EHABILITATION CENTER		1	30 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 000	INITIAL COMMEN	TS	F	000			
		ompliance with the CFR Part 483, Subpart B for acilities (General Health			·		
		,					
:							

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

PRINTED: 02/29/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		345155	B. WII	1G			C 5/2012
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		23	EET ADDRESS, CITY, STATE, ZIP CODE DEAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 000	The facility is in co	ompliance with the 2 CFR Part 483, Subpart B for Facilities (General Health	L.	000	DEFICIENCY)		
		INCOMENDATION DEPOSE CENTATIVE SE			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.

PRINTED: 01/27/2012 RTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - BUILDING 01 B. WING 345155 01/24/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET RANDOLPH HEALTH AND REHABILITATION CENTER ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K061 LIFE SAFETY CODE 02/09/12 K 061 NFPA 101 LIFE SAFETY CODE STANDARD K 061 SS≍D STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm The facility's automatic sprinkler system will sound when the valves are closed. has been updated to include electrical 72, 9, 7, 2, 1 supervision to the pressure operated flow switch on the dry system. This was completed on 1/27/12. The facility has created an audit tool to inspect the electrical supervision unit This STANDARD is not met as evidenced by: monthly to ensure it is functioning A. Based on observation on 01/24/2012 the appropriately. This is to be conducted facility has three (3) NFPA 13 sprinkler systems monthly by the Maintenance Director one (1) dry and two (2) wet. The pressure and/or maintenance assistant. Quarterly, operated flow switch on the dry system was not the system will be inspected by an outside electrically supervised. agency approved and licensed to inspect 42 CFR 483.70 (a) Fire Suppression Systems. This will begin 1/27/11. All maintenance staff has been in-serviced on how to inspect the new device for proper functioning. This was completed on 2/7/12. The facility will review the monthly and quarterly audits in the monthly QA&A. At this time we will review all findings of the audit and determine frequency and duration of ongoing audits.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

WHA

2-9-12

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STATEMENT OF DE AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG 01 - BUILDING 01	(X3) DATE : COMPL	
		345155		- To Bolizanto VI	01/2	24/2012
NAME OF PROVIDE		HABILITATION CENTER] :	REET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET ASHEBORO, NC 27203	~	24/2012
	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
SS=D Requivalver will so 72, 9. This S A. Ba facility one (1 opera electri	ired automatics supervised sound when the 7.2.1 STANDARD is sed on observing thas three (3) or y and two	s sprinkler systems have so that at least a local alarm a valves are closed. NFPA s not met as evidenced by: vation on 01/24/2012 the NFPA 13 sprinkler systems (2) wet. The pressure on the dry system was not ed.	K 061			
ABORATORY DIRECTO	OR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	1	(X6) DATE

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TATEMENT OF DEFICIENCIES	WW. BROWDERFORMER			OMB N	0.0938-0
ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 02 - BUILDING 02	(X3) DATE	
	345155	B. WING			
IAME OF PROVIDER OR SUPPLIER					24/2012
RANDOLPH HEALTH AND REF	ABILITATION CENTER	230	ET ADDRESS, CITY, STATE, ZIP CODI EAST PRESNELL STREET HEBORO, NC 27203	Ē	
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES	ID T			
LUCELIX (ENCH DELICIENCY)	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOHLDRE	(X5) COMPLET DATE
If there is an automa installed in accordant for the Installation of provide complete coubuilding. The system accordance with NFP Inspection, Testing, a Water-Based Fire Prosupervised. There is supply for the system systems are equipped	a reliable, adequate water Required sprinkler with water flow and tamper lectrically connected to the	K 056	,		
sprinkler heads in the green bulbs which indirating. You must have	ot met as evidenced by: ion on 01/24/2012 the cooler and the freezer had cales a high temperature your sprinkler designer ne proper heads for this	5,0	erinkler controc		2.9-1
ATORY DIRECTOR'S OR PROVIDER/SI	UPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE) DATE

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