STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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 cited as a result of the complaint investigation conducted as a part of the recertification survey.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164	F164-The Director of Nursing has inserviced all nurses and med aides on privacy and the importance of covering the MAR. MAR covers have been created to prevent this issue from reoccurring. The DON or designee will make rounds three times weekly for three weeks, then once weekly for two weeks. The findings will be brought to the QA committee for discussion and interventions as needed.	4/6/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin K. Wynn, NHA — TITLE: Administrator — (X6) DATE: 4/6/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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 164	Continued From page 1 Based on observation, facility record review and staff interview the facility failed to provide privacy while leaving the medication administration record (MAR) open and unattended for 1 of 10 residents (resident # 8) and giving eye drops to 1 of 10 residents (resident #9) in the hall during medication administration. 1. Resident # 8 was admitted to the facility on 8/5/2008 with cumulative diagnosis of cerebrovascular accident, depression, anxiety, chronic pain, hypertension, insomnia, agitation, left hemi-paresis, dementia with behavioral disturbances, and diabetes mellitus. The resident was coded on the most recent Minimum Data Set (MDS) dated 12/09/2011 as being moderately impaired cognitively. On 3-21-2012 at 09:00 am the Medication Aide (MA) was observed to walk away from the medication cart leaving the Medication Administration Record (MAR) open to resident #8 ' s private information to give medications to the resident. The MAR had the resident ' s name listed along with her medications. The MAR could have been read by anyone. On 03/21/2012 at 09:08 am an interview with the Director of Nursing (DON) indicated it was her expectation that staff always protected the privacy of the residents, which included closing the MAR after viewing it. On 03/21/2012 at 1:45 pm an interview with the MA indicated she had been informed during in-services that she was to protect the privacy of all resident ' s which included closing the MAR	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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 164	Continued From page 2 when not using. The MA indicated she just forgot to close the MAR. 2. Resident #9 was admitted to facility on 05/01/09 with cumulative diagnosis of glaucoma, dementia with psychosis, diabetes mellitus and hypertension. A review of the Minimum Data Set (MDS) dated 12/22/2011 indicated the resident was cognitively intact and had disorganized thinking. The CAA (Care Area Assessment) dated 4/1/2011 indicated the resident had short term and long term memory issues and poor decisions skills. Review of the physicians orders indicated an order for " Restasis 0.05% eye drops one drop both eyes two times a day. " The original date of the order was 11/9/2010. On 3-21-2012 at 08:45 am the Medication Aide (MA) was observed to give eye drops to resident #9 in the hallway. It was observed that other residents and staff were in the hall at the time of administration. On 03/21/2012 at 09:08 am an interview with the Director of Nursing (DON) indicated it was her expectation that staff provided privacy to all residents, which included not giving invasive medications in the public view. She indicated invasive medications included eye drops should had been given in the privacy of the resident ' s room. On 03/21/2012 at 1:45 pm an interview with the	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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 164	Continued From page 3 MA indicated she had been informed during in-services that she was maintain the privacy of all resident ' s which included not giving eye drops in the hall. The MA indicated she was suppose to give eye drops, patches, injections and other invasive medications in the privacy of the resident ' s room. The MA indicated she did not want the resident to leave before getting his eye drops.	F 164		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to notify a family member of a room change for 1 of 3 sampled residents (Resident # 69). Findings included: Record review indicated Resident #69 was admitted to the facility on 03/22/2011 with diagnoses that included Cognitive Impairment and Alzheimer's Dementia. Review of the resident's Minimum Data Set (MDS) dated 03/02/2012 revealed Resident #69 had moderate cognitive impairment and poor decision making skills. Review of the resident's "Admission Information Sheet" (face sheet) indicated the name of a	F 247	F247-The social worker has been inserviced, by the Administrator on rights to notice before changing a room or roommate. The social worker will complete a communication form to provide to the administrator any time a room change takes place. On this form the social worker will identify the person notified, time notified, and method of notification(ie-phone, person, mailing, etc.), and reason for the move. The resident/ responsible party will be fully informed of the room change prior to the change, with rationale. The forms will be completed for four weeks, the findings will be brought to the QA committee for review.	4/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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 247	Continued From page 4 family member who was the resident's Responsible Party (RP). Review of a Social Progress note dated 05/26/2011 indicated "Resident was moved to another room. No discomfort, adjusting fine. RP is aware of the move". The note was signed by the facility Social Worker(SW). In an interview with the resident's family member/responsible party on 03/19/2012 at 4:20 PM, she reported the resident was moved to a different room some time during the past year, and she was not notified prior to the move. She reported she visited the resident several times a week, and when she came on that day, neither the resident nor her belongings were in her room. She revealed she asked a staff member where the resident was. She reported she was told by the staff member the resident was moved to a different room. She further indicated she was never told why the move occurred. In an interview with the facility SW on 03/20/2012 at 2:15 PM, she reported "This resident's family member/responsible party is the person that I notified for any change. She would have been the person I called for the room change. I cannot remember whether I called or spoke to the family member. I may have attempted to call the family member and did not reach them. I ordinarily write RP notified if I actually talked to them, and since I didn't write that in my note, it is possible I did not get an answer when I called. I would not have left a message, because some people do not want me to leave messages about a resident". In an interview with the facility administrator on	F 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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 247	Continued From page 5 03/20/2012 at 2:20 PM, he indicated it was his expectation when a resident was moved to a different room, the facility should notify the resident's family member of the move and the reason for the move.	F 247		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interviews, the facility failed to provide adequate lighting in 1 of 13 sampled residents' rooms (resident #58). Findings include: Resident #58 was admitted to the facility on 8/18/11 with multiple diagnoses including history of cataracts. Review of the MDS (Minimum Data Set) dated 2/27/12 indicated the resident was cognitively intact. The MDS indicated he required one-person physical assistance with his activities of daily living (ADLS). The MDS indicated the resident had adequate vision and used corrective lenses. The resident indicated reading was "very important" on the MDS interview for activities preferences. In an interview on 3/20/12 at 9:21AM, resident #58 stated the light over his bed had not been working since he was admitted to the facility. The resident stated he had reported it to the "maintenance man." He added "they all know	F 256	F256-The light was repaired prior to the exit of the survey. The maintenance department has been inserviced, by the Administrator on proper lighting requirements. The maintenance department will make rounds three times weekly for three weeks, then once weekly for three weeks. The findings will be addressed, and brought to the QA committee for review and further intervention if needed.	4/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

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F 256	Continued From page 6 about it." The resident stated he needed the light to read and watch TV. An observation on 3/20/12 at 9:32AM revealed a wall mounted fluorescent light fixture at the head of the resident's bed. Observation revealed no bulbs were in place. An observation of the light fixture on 3/20/12 at 4:45PM revealed no bulbs were in place. An observation of the light fixture on 3/21/12 at 9:05AM revealed no bulbs were in place. An observation of the light fixture on 3/21/12 at 12:05PM revealed no bulbs were in place. In an interview on 3/21/12 at 2:03PM, the administrator stated three department heads made scheduled rounds each day. Each department head checked ten rooms per day. All issues or concerns with the residents' rooms were reported to the administrator and corrected on site immediately. The administrator double checked to be sure issues were resolved the same day. Concerns were discussed in the Quality Assurance (QA) meetings. The administrator provided a copy of the facility's Daily QA Rounds Sheet the department heads used for their room audits. "Replace light" was one of the items listed on the checklist. Record review revealed resident #58's room was checked on 3/14/12 and "needed light bulb replaced" was noted on the QA Rounds Sheet. In an interview on 3/21/12 at 2:25PM, the	F 256		

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F 256	Continued From page 7 Maintenance Director stated he had one assistant and they both made rounds to inspect the residents' rooms daily. He also reviewed the Daily QA Rounds Sheets and checked with the department heads and nursing assistants to see if there were any problems. Any repairs or replacements were completed as soon as they were reported. The bathroom bulb had been replaced in resident #58's room on 3/14/12 but no one had reported that the fluorescent bulbs were out. The Maintenance Director stated he had the 4 foot fluorescent bulbs on hand and would replace them in resident #58's room today. In an interview on 3/21/12 at 2:51PM, the Maintenance Director stated the light had been fixed in resident #58's room. In an interview on 3/21/12 at 2:57PM, resident #58 stated the light over his bed was now working.	F 256		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	F441-All nurses and med aides have been inserviced by the Director of Nursing on proper hand washing, correct use of hand sanitizer, and infection control principles. The DON or designee will make rounds three times weekly for three weeks, then one time weekly for two weeks to ensure that continued compliance is achieved. The findings from the rounds will be brought to the QA committee for review, and appraisal.	4/6/12

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	345252	A. BUILDING _____ B. WING _____	C 03/21/2012

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F 441	Continued From page 8 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility record review and staff interview the facility failed to ensure hand washing was utilized between 2 of 10 residents (resident # 9 and resident # 8) during medication administration. On 03/21/2012 at 08:57 am the Medication Aide (MA) had been observed to give eye drops to resident #9 and removed her gloves. She did not wash her hands, went to the medication cart and did not utilize the hand sanitizer available. The MA was observed to immediately prepare pills for resident #8. The MA was observed going into	F 441		

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F 441	Continued From page 9 resident #8 ' s room and gave the medications. She did not wash her hands before administering the medication. On 03/21/2012 at 09:08 am an interview with the Director of Nursing (DON) indicated it was her expectation that staff were to wash their hands before and after wearing gloves and between two residents. The DON indicated she expected all staff to follow the infection control policy. On 03/21/2012 at 1:45 pm an interview with the MA indicated she had been informed during in-services that she was to wash her hands before and after wearing gloves and between residents. The MA indicated she just forgot to wash her hands.	F 441		

Warsaw Health & Rehab

Privacy Rounds

Date:_____ Rounds by:_____

MAR Covered when left unattended:_____

Any Resident Receiving Eye Drops In Hallway:_____

Privacy provided throughout round:_____

Concerns to address to QA
found:_____
_____
_____
_____
_____
_____

Signature:_____ Date:_____

Warsaw Health & Rehab

ROOMCHANGE NOTIFICATION FORM

Date:_____

Resident being moved:_____

Resident/RP Notified:_____

Date and Time of Notification:_____

Method of Notification:_____

Reason for Moving:_____

Social Worker Signature:_____

Administrator Approval:_____

Warsaw Health & Rehab

Resident Lighting QA

Date:_____ Wing:_____

Note any light fixtures in need of attention:

Bathrooms:_____

Bedroom:_____

Over the Bed:_____

Lamps:_____

Nightlights:_____

Maintenance Signature:_____

Administrator Signature:_____

All problems if any resolved?_____

Warsaw Health & Rehab

Hand Washing/Sanitizing/Infection Control QA

Date:_____

Nurse/MA observed:_____

Were gloves used appropriately:_____

Was Handwashing done correctly and timely:_____

Was hand sanitizer used as needed:_____

Were overall infection control principles followed:_____

Observer:_____

Any findings requiring
attention:_____
_____
_____

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
	345252	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V-protected construction, one story, with a complete automatic sprinkler system.	K 000	RECEIVED	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following	K 018	K018-The administrator has Inserviced the maintenance staff of the importance of proper latching doors on 04/26/2012. The gap in the door of room 28 has been repaired, and the beauty shop door now latches appropriately. The doors will be inspected by maintenance weekly for three weeks, then monthly for two months to ensure proper latching.	4/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin R. Wynn — TITLE: Administrator — (X6) DATE: 4/27/12

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.

GW

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K 018	Continued From page 1 items were noncompliant, specific findings include: bedroom door # 28 had gap of 1/4 inch greater at top of the door between the door and it's frame. Also beauty shop door would not close and latch.	K 018		
K 045 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: no lighting on the exit discharge path outside the Middle Hall. Lighting must be arranged to provide light from the exit discharge leading to public way(parking lot).	K 045	K045-The administrator has inserviced the maintenance staff on egress illumination on 04/26/2012. The double bulb lighting fixtures have been added to the egress path area to provide sufficient lighting. The exterior lighting will be inspected biweekly for one month, then monthly for two months.	4/27/12
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	see next page →	

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	345252	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/10/2012

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(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 062	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: A. sprinkler heads in kitchen have excess lent on them. B. facility could not provide documentation that sprinkler system has had 5 year obstruction investigation and 3 year flow test. 42 CFR 483.70(a)	K 062	K062- The administrator has inserviced the maintenance department on monitoring cleanliness of the sprinkler heads and importance of the routine sprinkler tests. The sprinkler heads in the kitchen have been cleaned. The 5 year obstruction test has been completed and the 3 year flow test. Maintenance will make rounds monthly for two months to ensure that sprinkler heads are cleaned.	5/24/12
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: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following items were noncompliant, specific findings include: facility could not provide documentation that generator has had load banking test within	K 144	K144-The administrator has inserviced maintenance on the importance of a load banking test. The generator has been load banked as required and will be done as required from here on out. Maintenance staff will monitor the generator load monthly.	5/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCARE	214 LANEFIELD RD WARSAW, NC 28398

(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	Continued From page 3 past year. 42 CFR 483.70(a)	K 144		