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
	345160	A. BUILDING _____ B. WING _____	05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK RD WILMINGTON, NC 28411

(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 was found to be in compliance with the Medicare/Medicaid Long Term Care Regulations 42 CFR Part 483, Sub part B during a recertification survey. Event ID IP9411.	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.

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-039

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	345160	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/07/2012 the door to the large storage room being held open. B. Based on observation on 06/07/2012 the door to the large storage room near the laundry was being held open. 42 CFR 483.70 (a)	K 029	Cornelia Nixon Davis acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality care of the residents. The plan of correction is submitted as written allegation of compliance. Cornelia Nixon Davis' response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies and the Plan of Correction nor does it constitute an admission that any deficiency is accurate. Further, Cornelia Nixon Davis reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/07/2012 the locked gate at the Altzheimers unit did not have an on and off switch. B Based on observation on 06/07/2012 the	K 038	**Plan of Correction** **K029** a. The two storage room doors identified as propped open	7-22-12

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 th other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 da 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 1 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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	345160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 1 locked doors (cross corridor doors) did not have an on and off switch. This was corrected at the time of the survey. 42 CFR 483.70 (a)	K 038	were corrected before the end of the Life Safety Survey. b. Other storage room doors throughout the facility have been evaluated to ensure proper positioning in order to prevent the spread of a possible fire. c. Kitchen and Laundry staff has been retrained regarding the requirements fire safety doors being kept closed to prevent the spread of fire. d. The Safety Committee will monitor storage door positions weekly for 4 weeks, then monthly for 3 months. The Quality Care Committee will review the on-going inspections by the Safety Committee monthly for 3 months, provide direction for follow up as deemed necessary and determine the frequency and/or need for continued monitoring. **K038** a. The fire doors separating West 1 and West 2 units	7-22-12

were corrected before the end of the Life Safety Survey. An on-off switch was added to the locked garden gate of the Alzheimer's unit.

b. Other locked doors in the Alzheimer's unit have been evaluated to insure that there is an on-off switch installed.
c. Maintenance staff has been retrained regarding the requirement that exits are readily accessible at all times in accordance Fire Safety practices.
d. The Safety Committee will monitor for proper fire door functioning weekly for 4 weeks, then monthly for 3 months. The Quality Care Committee will review the on-going inspections by the Safety Committee monthly for 3 months, provide direction for follow up as deemed necessary and determine the frequency and/or need for continued monitoring.