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
	345487	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BLVD HAVELOCK, NC 28532

(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 LTC Regulations 42 CFR part 483 subpart B during the recertification survey of 05/16/12.	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.

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	345487	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BLVD HAVELOCK, NC 28532

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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 construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Cherry Point Bay Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings that are factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Cherry Point Bay's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cherry Point Bay reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 029 SS=E	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: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: 1. soiled and clean linen room door would not close and latch for smoke tight seal(laundry	K 029	K 029(SS=E) (1.) The door to the soiled and clean linen room (at the laundry department was adjusted on 5-31-12 by the Maintenance Supervisor so that it closes and latches appropriately to accommodate a smoke tight seal. All other fire doors inside the facility have been inspected by the Maintenance Supervisor to ensure that each door closes and latches correctly. This was completed on 6-6-12 with no further deficiencies noted.	5-31-1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Courtney Collier — Administrator — 6/15/12

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.

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	345487	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/31/2012

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K 029	Continued From page 1 room). 2. Medical Records door not self closing. 42 CFR 483.70(a)	K 029	All facility staff have been in-serviced to report doors that do not close or latch properly to the Maintenance Supervisor immediately. This in-service was done on 6-6-12.	6-15-12
K 045 SS=D	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 11:30 am onward, the following items were noncompliant, specific findings include: activity room leaves patient in darkness to get to exit egress.	K 045	All facility fire doors will be inspected quarterly by the Maintenance Supervisor. K 029(SS=E) (2.) The self closure device for the medical records storage door was ordered, and upon arrival was installed by the Maintenance Supervisor on 6-15-12. K 045(SS=D) (1.) The facility has scheduled for an outside vendor, C.T.E., Inc., to correct the lighting in the activity room so that room will not be left in the dark and has illumination to exit egress at all times. This correction will be done on or before 6-19-12.	6-19-12
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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following	K 062	No other areas of the facility are noted to be without illumination to egress. K 062 (SS=E) (1.) Excess lent/dust was cleaned from sprinkler head in laundry department on 5-31-12. All sprinkler heads inside the facility were cleaned on 5-31-12. An in-service was completed on 5-31-12 with all Housekeeping/Laundry personnel as well as the Maintenance Supervisor by the Administrator regarding maintain-	

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K 062	Continued From page 2 items were noncompliant, specific findings include: all sprinkler heads located in laundry area have excess lent on head. 442 CFR 483.70(a)	K 062	ing sprinkler heads. Sprinkler heads will be cleaned weekly and as needed to prevent build up of lent/dust and maintain reliable operating condition.	5-31-1
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: if stored within the same enclosure, empty cylinders shall be segregated and designated from full cylinders. Empty cylinders were mix wit full cylinders rack at time of survey. 42 CFR 483.70(a)	K 076	K 078 (SS=E) (1.) On 5-31-12 the Supply Clerk reorganized tanks in the oxygen supply room so that all full and empty oxygen containers were properly segregated by rack. This is the only oxygen storage room at the facility. On 5-31-12 all Nurses and Certified Nursing Assistants were in-serviced by the Staff Facilitator regarding oxygen storage. This in-service specifically included that full and empty oxygen containers have to be segregated by rack. Oxygen storage was monitored from 6-4-12 through 6-8-12 daily by the QI nurse with no further deficiencies noted. Oxygen storage will continue to be monitored weekly at a minimum by the supply clerk who will then report findings to the QI team. Interdisciplinary QI team will meet weekly for four (4) weeks to discuss findings of weekly audits. From there QI team will increase interventions if needed.	5-31-1