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

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED	
		345504	8. WING			08/29/2012		
NAME OF PROVIDER OR SUPPLIER J ARTHUR DOSHER MEM HOSP				92	EET ADDRESS, CITY, STATE, ZIP CODE 4 N HOWE STREET DUTHPORT, NC 28461			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)			(X5) COMPLETION DATE	
F 000	00 INITIAL COMMENTS		F	000			: : !	
	The facility is in co requirements of 42 Long Term Care Fa Survey). Event ID	CFR Part 483, Subpart B for acilities (General Health						
			 	:				
	·			:				
	V DIDEOTORIO CO 1700 (17	DER/SUPPLIER REPRESENTATIVE'S SIG	NATHE	!	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.

DEPART	PRINTED: 10/15/2012 FORM APPROVED OMB NO. 0938-0391								
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345504		(X1) PROVIDER/SUPPLIER/CLIA	1' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		B. WING			Ŀ	10/11	1/2012		
NAME OF PROVIDER OR SUPPLIER J ARTHUR DOSHER MEM HOSP				STREET ADDRESS, CITY, STATE, ZIP CC 924 N HOWE STREET SOUTHPORT, NC 28461			DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IO PREF TAG	ĐΧ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	H.E.	CTION DULD BE PROPRIATE	(X6) COMPLETION DAYE	
K 000	INITIAL COMMENT	rs	K	000					
K 052 SS=E	conducted as per T at 42 CFR 483.70(at 242 CFR 4	de(LSC) survey was ine Code of Federal Register a); using the Existing Health LSC and its referenced uilding is Type V construction, implete automatic sprinkler ising NCSBC special locking in elemined during the survey in FETY CODE STANDARD is required for life safety is id maintained in accordance and Electrical Code and NFPA is an approved maintenance in complying with applicable iPA 70 and 72. 9.6.1.4	K	052	Dosher has contracted fire slarm contractor the dialer with a new detect any communicate failures. It will report the fire alarm panel the manned 24/7. Contrasan annual total system report to Director of I Operations. It will be 10/30/12.	er te to to to th	eplace that will n ouble to is will do eck and	10/30/12	
	Surveyor: 27871 Based on observati approximately 8:30 items were noncominclude: there was r Alarm Control Pane connection.	s not met as evidenced by: ons and staff interview at am onward, the following opliant, specific findings no audible/visual signal at Fire el with loss of telephone							
LABORATORY	DIRECTOR'S OR PROVID	ersupplier representative's sign	VATURE		TITLE	1	Planto	(X8) DATE	
	in Rec		1.45 '	22124	VINE OVO	╃╌			
Any deficienc	y statement ending with a	an esterisk (*) denotes a deficiency whi	ch the in	งแนนอก	may pe excused from correcting	100	ildidid di primiri localash are et	ningu illat de 90 dava	

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Facility 10:20000003 923266

PRINTED: 10/15/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 B. WING 10/11/2012 345504 STREET ADDRESS, CITY, STATE, ZIP COL NAME OF PROVIDER OR SUPPLIER 924 N HOWE STREET J ARTHUR DOSHER MEM HOSP SOUTHPORT, NC 28461 PROVIDER'S PLAN OF COR LECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DAYE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX PREFIX TAG TAG DEFICIENCY) K 052 | Continued From page 1 K 052 42 CFR 483,70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 056 K 056 SS≍E If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Dosher has contracted Water-Based Fire Protection Systems. It is fully Simplex/Grinnell to replace one supervised. There is a reliable, adequate water supply for the system. Required sprinkler head in south sun room and to systems are equipped with water flow and tamper clean and inspect all beads in switches, which are electrically connected to the Nursing Center. Quarterly building fire alarm system. 19.3.5 inspections will be done by the contractor and reported to the 11/09/12 Director of Plant Operations This STANDARD is not met as evidenced by: Surveyor, 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include; sprinkler heads in recreation Center and H/A Convenience Center have excess lent build up on heads. 42 CFR 483,709(a) NFPA 101 LIFE SAFETY CODE STANDARD K 076

FORM CMS-2567(02-99) Praylous Versions Obsoleto

Medical gas storage and administration areas are

protected in accordance with NFPA 99, Standards for Health Care Facilities.

K 076 SS≒D

Event ID: C17021

Facility ID: 20000003

continuation sheet Page 2 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/6UPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 345504 10/11/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP COD 924 N HOWE STREET J ARTHUR DOSHER MEM HOSP SOUTHPORT, NC 28461 PROVIDER'S PLAN OF CO DECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION DATE (X4) ID PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 078 Continued From page 2 K 076 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. Staff has been re-educated on the importance of storing Daygen E (b) Locations for supply systems of greater than 3,000 cu.ft, are vented to the outside. NFPA 99 tanks in their respective place. Full 4.3.1.1.2, 19.3.2.4 with full and empty with empty. Director of Nursing Center or designee will monitor with 10/12/12 observation on daily bunds. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: empty cylinders were mix in with full cylinders at North side nursing station. 42 CFR 483.70(a)

10-30-2012 11:03

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