CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) M		LE CONSTRUCTION	FOR OMB No	D: 10/31/2012 M-APPROVED O: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUII			(X3) DATE SU COMPLE	
		345104	B. WIN	'G			18/2012
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
KINDRED	NURSING & REHABILIT	ATION-ZEBULON		ı	09 W GANNON AVE EBULON, NC 27597		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BÉ	(X5) COMPLETION DATE
F 253 SS=E	maintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation review of maintenance to clean the heating strooms (101, 102, 106, 114, 115,116, 117, 20209, 211, 214, 216, 2 repair the damaged with (Resident #138). The findings included During initial tour on 10 observations in the for 205,206,207, 203, 202102, 106, 108,107,10215,116, 117) had a last of gray dirt/dust on the systems The heat was blowing throughout the housekeepers present staff cleaned the heat Follow- up observation rooms heating system through 9:31AM, the last the same condition and to blow throughout the	ide housekeeping and a necessary to maintain a comfortable interior. is not met as evidenced ans, staff interviews and e records, the facility failed systems in resident 108,107,109, 111, 112, 113, 2,204, 205,206,207, 203, 12). The facility failed to wheelchair for 1 of 1 resident 108,107,109, 111, 112, 113, 114, arge volume of heavy build e front panels of the heating son and gray dirt/dust e room. There were two ton the halls, but neither ing system in the rooms ans was done of resident as on10/17/12 at 9:20AM meating systems remained in the dirty/dusty continued e rooms. To no 10/17/12 at 9:22AM,	F	253	This Plan of Correction is the center's creat allegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed solit is required by the provisions of federal and the set in rooms 101, 102, 1107, 109, 111, 112, 113, 116, 117, 202, 204, 205, 2203, 209, 211, 214, 216 and were cleaned removing and dirt/dust. Resident #138 were cleaned removing and dirt/dust. Resident #138 were provided a wheelchair in grepair without missing tire functioning brakes and secrests. 2. ED will conduct room to reobservations to compile a leating vents in need of cleaned wheel chairs in need of cleaned when cleaning resident room will in-service Maintenance. Director regarding wiping units weekly, cleaning filter monthly and quarterly clean with non-acid coil cleaner. in-service staff if they not equipment is in need of repreplace the equipment, if p and complete a work order repair of the wheelchair. Evalidate heating units, iden initial audit, are cleaned. It	of correction by the conclusions he plan of elly because and state law. Iting 06, 108, 14, 115, 06, 207, d 212 y gray ras cood material, ured arm com ist of caning f repair. eeping vents ms. ED edown ers ning ED will resident coir to cossible, form for D will tified on	11/06/12
	~ //	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
10	slen Ah	nd			Administrator		1 /06/12

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 240D11

Facility ID: 923220

If continuation sheet Page 1 of 6

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILI			С	
		345104	B. WING	³ —		10/18/2012	
	ROVIDER OR SUPPLIER NURSING & REHABILIT	ATION-ZEBULON	,	50	EET ADDRESS, CITY, STATE, ZIP CODE 19 W GANNON AVE EBULON, NC 27597		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 253	fixtures, cleaning batt mopping, maintenance for cleaning and chan heating system. HK# any of the heating syst that were observed ro During an observation the Maintenace direct both halls and swiped panel of the heating systhere was gray dirty/d the panels. Maintenant that the dirty/dusty pathe hall area of reside The maintenance direct housekeeping staff with the front panels/grove maintenance did the consistency of the last cleaning and 8/8/12. During an observation HK supervisor, HK#2 tour resident rooms across the front panel systems and acknowl of dirt/dust present. The HK supervisor staff was expected to heating systems on a doing there general heacknowledged that the cleaned.	led wiping down the light brooms, sink, sweeping be department responsible ging the filters on the lidid not clean or wipe down stem for the following rooms from 101, 102, 104. In on 10/17/12 at 9:38AM, for toured resident rooms on libis fingers across the front system and acknowledged usty matter in the groves of fince director ackowledged nels could be observed from ant rooms.	F 2	253	This Plan of Correction is the center's creditallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and validate wheelchair in need repair, identified on initial repaired or replaced. ED of designee will audit three he units and three wheelchairs to validate they are clean as good repair. 4. Results of audits will be provided to to center's Performance Improvement Committee in for a minimum of three monounce. Improvement Committee will review and audit results making further recommendations as needed. Performance Improvement Committee will determine to ongoing monitoring beyond three month minimum to endongoing compliance is main	f correction by the conclusions ite plan of ly because d state law. I of audit, are eating s weekly nd in esented nonthly onths. I evaluate r d. need for d the nsure	11/06/12

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	COMPLETED		
		345104	B. WNG			C 10/18/2012		
	OVIDER OR SUPPLIER	TATION-ZEBULON	. I <u></u>	5	REET ADDRESS, CITY, STATE, ZIP CODE 109 W GANNON AVE L'EBULON, NC 27597			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 253	8:30AM, the HK sup was a 7 step cleaning housekeeping staff voleaning resident root that all the housekeethe expecations of the rooms and the heating. During an interview administrator indicat staff has been in-ser cleaning resident root. Review of the weekl maintenance log ide description, date and sheet revealed the unweekly, filters should units should be removith non-acid coil cle 4/28/12 through 8/8/	ervisor, indcated that there g process that the vas responsible for when oms. HK supervisor indicated eping staff was in-serviced on ne daily cleaning of residenting systems. on 10/18/12 at 2:15PM, the ed that the housekeeping vice on the expectation of	F	253				
	9/25/12. Review of hassessment dated 1 behaviors or cognitivinitial tour of the faci resident #138 complin poor repair and the but no one had done was noted to be mis material in multiple heft brake was loose	as admitted to the facility als minimum data set 0/2/12 revealed he had no be impairments. During the lity on 10/15/12 at 9:30 AM ained that his wheelchair was at he had told the rehab staff anything. The wheelchair sing large pieces of tire ocations on both tires. The when engaged and the right cured and easily lifted away						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		c .	
		345104	B. WNG		10/1	8/2012
	ROVIDER OR SUPPLIER NURSING & REHABILIT	ATION-ZEBULON	5	REET ADDRESS, CITY, STATE, ZIP CODE 509 W GANNON AVE ZEBULON, NC 27597	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253	interviewed and indicany concerns with resonate said the rehab do for the assignment of unaware of who assigned the wheelchair was concern and she indicated and the responsibility maintenance concern Director. On 10/17/12 at 10:50 Director indicated he concerns with the whole that is but he dependent concerns with the whole concerns with t	AM the Rehab Director was ated she was not aware of sident #138 's wheelchair. Epartment was responsible wheelchairs but she was gned resident #138 his chair. Ebserved by the Rehab cated the wheelchair should ed to a resident. She said it of all staff to report s to the Maintenance AM the Maintenance AM the Maintenance was not aware of any eelchair assigned to resident inely spot checked the ed on staff to report eelchairs. AM the Director of Nursing hair and indicated she would enaid it was the responsibility by maintenance concerns via ed repairs. BURSE STAFFING the following information on and the actual hours worked ories of licensed and aff directly responsible for	F 253	Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed sole it is required by the provisions of federal and posted on a daily basis cur includes: facility name, the date, the total number and actual hours worked by the categories of licensed and unlicensed nursing staff di responsible for resident car shift including Registered Licensed Practical Nurses, Nursing Aides and residen The current posting includes staffing data specified on a basis at the beginning of extra the current posting is in a readable format and locate prominent place readily actoresidents and visitors at nurses station.	of correction t by the conclusions the plan of ely because and state law. ormation rently e current the e rectly re per Nurses, Certified at census. es nurse a daily ach shift. clear and d in a cessible the e 11:00 sponsible ing in- 00 a.m. osted a is to	11/06/12

PRINTED: 10/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		345104	B. WING	s		1	C 8/2012
	ROVIDER OR SUPPLIER NURSING & REHABIL	ITATION-ZEBULON		50	EET ADDRESS, CITY, STATE, ZIP CODE 19 W GANNON AVE EBULON, NC 27597		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 356	vocational nurses (a - Certified nurse or Resident census. The facility must pospecified above on of each shift. Data or Clear and readab or In a prominent planesidents and visito. The facility must, up make nurse staffing for review at a cost standard. The facility must mastaffing data for a more required by State late. This REQUIREMENT by: Based on observate facility failed to post licensed and unliced days of the recertification. The posted staffing	rses. tical nurses or licensed as defined under State law). e aides. st the nurse staffing data a daily basis at the beginning must be posted as follows: the format. the readily accessible to rs. con oral or written request, data available to the public not to exceed the community stintain the posted daily nurse sinimum of 18 months, or as w, whichever is greater. IT is not met as evidenced ion and staff interviews the the actual hours worked by used nursing staff for fours	F3	356	This Plan of Correction is the center's credicallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and facility name, the current does not constitute and unlicensed number and the actual worked by the categories of licensed and unlicensed numbers and the actual worked by the categories of licensed and unlicensed numbers and the actual worked by the categories of resident care per shift inclusively Registered Nurses, Certified Aides and resident census. Current posting includes numbers and staffing data specified on a basis at the beginning of ear the current posting is in a creadable format and located prominent place readily accurated to residents and visitors at the ED will conduct an audicate validate posted Nurse Staff Information includes: facility the current date, the total mand the actual hours worked categories of licensed and unlicensed nursing staff directions and the actual hours worked categories of licensed and unlicensed nursing staff directions and the responsible for resident care shift including Registered Mandally Practical Nurses, and the actual Nurses, and the actual Nurses, and the practical Nurses, and the provision of	f correction by the conclusions are plan of ly because d state law. ate, the hours f rsing or ding d Nursing The rse daily ch shift. clear and d in a cessible he weekly it to fing ty name, nmber d by the ectly e per Jurses,	11/06/12
	station. One sheet was three shifts. The shifts and the facility cens	vas observed for each of the eet included the date, the shift us. The sheet also included ours worked for both licensed		de trade des des des des des de la companyo de la c	Nursing Aides and resident The current posting include staffing data specified on a basis at the beginning of each	s nurse đaily	

Facility ID: 923220

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLET		
		345104	B. WING		1	C 18/2012	
	ROVIDER OR SUPPLIER	ATION-ZEBULON	50	EET ADDRESS, CITY, STATE, ZIP CODE 09 W GANNON AVE EBULON, NC 27597	1 132	0.2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 356	and unlicensed nursing Observations made of 10/16/12 at 12:00 PM 10/18/12 at 1:20 PM 1	ng staff. n 10/15/12 at 9:30 AM, i, 10/17/12 at 10:30 AM and did not include the total nsed and unlicensed staff for i. ng was interviewed on and indicated that the third ible for the posted staffing. tion was for the actual hours and unlicensed nursing staff	F 356	This Plan of Correction is the center allegation of compliance. Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts alleg set forth in the statement of deficience correction is prepared and/or execute it is required by the provisions of fed. The current posting is readable format and leprominent place readit to residents and visito nurses station. 3. Results of audits will to center's Performant Improvement Commit for a minimum of three Performance Improve Committee will review audit results making for recommendations as a Performance Improve Committee will determine ongoing monitoring by three month minimum ongoing compliance is	plan of correction eement by the ged or conclusions ites. The plan of ed solely because eral and state law. Is in a clear and ocated in a ily accessible ors at the be presented ace ittee monthly ee months. The property of the further needed. The plan of correction was in a clear and ocated in a ily accessible ors at the beautiful accessible or at the interpretation of the months. The property of the further needed. The property of the property of the into ensure	11/06/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILE		E CONSTRUCTION 01 - MAIN BUILDING 0 (701)	(X3) DATE	\$URVEY
		345104	B, WING	·	**************************************	11/	09/2012
	PROVIDER OR SUPPLIER D NURSING & REHAE	BILITATION-ZEBULON	s	509	et address, city, state, zip code W gannon ave BULON, NC 27897		11.00
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG		'PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
SS¤E	This Life Safety Co conducted as per Ti at 42CFR 483,70(a) Care section of the publications. This bi (2II) construction, or automatic sprinkler: The deficiencies det are as follows: NFPA 101 LIFE SAF Doors protecting cor required enclosures hazardous areas are those constructed of wood, or capable of minutes. Doors in sirequired to resist the no impediment to the are provided with a rithe door closed. Durare permitted.	de(LSC) survey was the Code of Federal Register is using the Existing Health LSC and its referenced wilding is Type II unprotected the story, with a complete system. The system of the survey of the complete system of vertical openings, exits, or existing fire for at least 20 prinklered buildings are only passage of smoke. There is a closing of the doors. Doors neans suitable for keeping to doors meeting 19.3.6.3.6 3.6.3	K 00		Preparation and for execution of a plan of correction does not constitution and some statement by the proof the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared/and or executed solely because it is required by the provisions of federal and state law provisions of federal and state law that doors protecting corridor in other than required enclose vertical openings, exits, or he areas are substantial doors, suchose constructed of 1 ½ inches bonded core wood, or capabil resisting fire for at least 20 m. The opening in the wall at the return between the dining rockitchen will be sealed off with stud and 5/8 sheet rock to be closed smoke tight.	tute ovider nent ction r to ensure r openings ures of azardous uch as a solid e of ainutes, e tray om and h metal	
The state of the s				3.	The Director of Plant Operation assure this area remains smol	ce tight	i iyay — ya hada in a sana in a s
	,			4.	Findings would be discussed Performance Improvement C Meeting.		y
		not met as evidenced by: n on Friday 11/9/12 at				***************************************	
BORATORY	DIRECTOR'S OR DROWN	RISTIPPLIER REPRESENTATIVES SIGNA	Crube	ь.	Tirl C .		YRV DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 days allowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued togram participation.

JRM CMS-2567(02-99) Previous Versions Obsolete

Event 10:240021

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLJA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
			A, BUILDIN	G 01 - MAIN BUILDING 01		
		345104	B. WING _		11/0	9/2012
KINDREI		BILITATION-ZEBULON	\$ 2	REET ADDRESS, CITY, STATE, ZIP COI 09 W GANNON AVE EBULON, NC 27597 PROVIDER'S PLAN OF COF		α5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC DATE
K 018 K 025 SS≒E	approximately 8:00 noted: 1) The opening in the diverse of the dining equipped with a small representation of the kitchen and dinable to be closed so the kitchen and the kitchen and the least a one half hor accordance with 8 terminate at an atriprotected by fire-rapanels and steel for separate compartness floor, Dampers are penetrations of smitheating, ventilating 19.3.7.3, 19.3.7.5,	Am onward the following was the wall at the tray return room and kitchen is not noke control device or door. open to the exit corridor and doors and openings between ing room are required to be moke tight. AFETY CODE STANDARD The constructed to provide at ur fire resistance rating in an action of two ments are provided on each not required in duct oke barriers in fully ducted, and air conditioning systems.	K 018	Preparation and for executing plan of correction does not admission or agreement by of the truth of the facts alle conclusions set forth in the of deficiencies. The plan of is prepared/and or executed because it is required by the provisions of federal and stable all penetrations in the sall penetrations in the sall penetrations in the sall penetrations in the sall penetrations of barrier. 2. The Director of Plant Cascal all penetrations to required fire resistance smoke barrier through 3. The Director of Plant Cascal all penetrations are sealed with our preventive may program. 4. Findings would be discaperformance Improvem Meeting.	constitute the provider ged or statement correction solely the law, center to assure moke walls are ain the required the smoke operation will maintain the rating of the out the center, operation will assure all in compliance intenance	
	Based on observa approximately 8:00 noted: 1) The smoke barrl noncompliant: spe smoke walls on bot that was not sealed required fire resistar	is not met as evidenced by: tion on Friday 11/9/12 at Am onward the following was er was observed as clific findings include the th hall have holes/penetrations I in order to maintain the ance rating of the smoke walls in the rooms and hall				

		A MICDICAID SERVICES	,			ONI DIMO	<u>, 0958-038</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEWCLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENT/PICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		345104	B. WING			11/0	9/2012
	SUMMARY STA	BILITATION-ZEBULON	l ID	50	EEY ADDRESS, CITY, STATE, ZIP CODE 9 W GANNON AVE BULON, NC 27597 PROVIDER'S PLAN OF CORR		,
PREFIX TAG	I. (EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRET TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
K 026 K 038 SS=D		smoke wall) FETY CODE STANDARD	K C		Preparation and /or execution of plan of correction does not consider admission or agreement by the of the truth of the facts alleged conclusions set forth in the stat of deficiencies. The plan of cois prepared/and or executed sol because it is required by the provisions of federal and state	stinue provider or ement rection ely	
	Exit access is arran accessible at all tim 7.1. 19.2.1	ged so that exits are readily es in accordance with section			1. The Director of Plant Constructed all employed in service on 11/09/12 and operation of the masswitch for the exit door with mag locks.	s through an on the reason ster override	12/21/12
K 056 SS=F	Based on observation approximately 8:00 in noted: 1) When question is master override swith equipped with mag to the last an automatinately in accordant for the installation of provide complete comple	ecks and it function. FETY CODE STANDARD atic sprinkler system, it is not with NFPA 13, Standard Sprinkler Systems, to verage for all portions of the in is properly maintained in PA 26, Standard for the	K 04	A COLUMN TO THE REAL PROPERTY OF THE PARTY O	2. The Director of Plant O continue the same in ser cach shift's fire drill. 3. All new hires will be or function of the master or during general orientation. 4. In service status and new discussed in center's many Performance Improvem meeting.	vice during ientated on the verride switch on. ed will be onthly	ı

STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A. BUI	LDING	e construction 01 - Main Building 01	(X3) DATE COMF	SURVEY LETED
KINDRED NURSING & REHABILITATION-ZEBULON (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 056 Continued From page 3 building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) There are sprinkler heads in the facility rated for intermediate Temperature Classification, Glass Bulb Color of Yellow temperature rating of (176°F) and Green (200°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). (b) Kitchen, kitchen dry storage room, storage/water heater room adjacent to kitchen. 2) The heat sensitive element on the backflow device for the sprinkler face when tested did not maintained clean in good condition, 3) The temper alarm on the backflow device for the sprinkler face when tested did not provide an ordinary to a provision of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions are forth in the statement of deficiencies. The plan of correction is prepared/and or executed solely because it is required by the provisions of federal and state law. 1. It is the practice of the center to assure that Sprinkler system are installed in accordance with NFPA standard. 2. An outside vendor has been contacted to replace yellow and green color glass bulbs with red temperature rating of (155 degree F) in locations (a) Front Covered oar port, walkway and vestibule; (b) Kitchen, kitchen dry storage room, storage/water heater room adjacent to kitchen. 3) The tamper alarm on the backflow device for the sprinkler face of the center to assure that Sprinkler	VIANTE OF	Do at an all	345104	O. VYII			11	/09/2012
REGULATORY OR LSC IDENTIFYING INFORMATION) K 056 Continued From page 3 building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) There are sprinkler heads in the facility rated for intermediate Temperature Classification, Glass Builb Color of Red temperature rating of (175°F) and Green (200°F) in place of Ordinary Temperature Classification, Glass Builb Color of Red temperature rating of (165°F). Locations (a) Front covered car port, walkway and vestibule. (b) Kitchen, kitchen dry storage room, storage/water heater room adjacent to kitchen. 2) The heat sensitive element on the backflow device for the sprinkler riser when tested dild not provide an add for the content on the provider of the content of the content to the sprinkler riser when tested dild not provide an add for the content of the content of the content to the content	KINDRE	ED NURSING & REHAI			509	W GANNON AVE	2	
Continued From page 3 building fire alarm system. 19.3.5 K 066 building fire alarm system. 19.3.5 In the statement of deficiencies. The plan of correction does not coustitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction desinsem. by the provide a function of deficiencies. The plan of correction desinsems by the provide all smission or agreement by the provide and state law. 1. It is the practice of the center to assure that Sprinkler system are installed in accordance with NFPA standard. 2. An outside vendor has been contacted to replace yellow and green color glass bulbs with red temperature rating of (155°F). In locations (a) Front Covered car port, walkway and	PREFIX	(MACH DEFICIENC)	Y MUST BE PRECEDED BY FILL	PREFI	<	(EACH CORRECTIVE ACTION S CROSS-REPERENCED TO THE AI	HOULD BE	COMPLETIO DATE
K 061 SS=D Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed, NFPA Vendor and thereby will request for a 30-day extension. K 061 SS=D Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed, NFPA The temper element of the band of the b	K 061 \$S=D	This STANDARD is Based on observat approximately 8:00 noted: 1) There are sprinkly for intermediate Ter Glass Bulb Color of (175°F) and Green Temperature Classis Red temperature Classis Red temperature ray Locations (a) Front and vestibule. (b) Kitchen, is storage/water heate 2) The heat sensitive heads in the laundry not maintained clear 3) The tamper alarm the sprinkler riser whalarm wen tested. 42 CFR 483.70(a) NFPA 101 LIFE SAF Required automatics will sound when the vertical strength of the sprinkler automatics will sound when the vertical strength in the sprinkler automatics will sound when the vertical strength in the sprinkler automatics will sound when the vertical strength in the	system, 19.3.5 s not met as evidenced by: ion on Friday 11/9/12 at Am onward the following was er heads in the facility rated mperature Classification, Yellow temperature rating of (200°F) in place of Ordinary fication, Glass Bulb Color of ting of (155°F), it covered car port, walkway ditchen dry storage room, r room adjacent to kitchen, re element on the sprinkler room are cover in lint and in in good condition, on on the backflow device for ien tested did not provide an error tested did not provide an error tested did not provide an error tested allerm		3	plan of correction does not coadmission or agreement by the of the truth of the facts allege conclusions set forth in the st of deficiencies. The plan of o la prepared/and or executed a because it is required by the provisions of federal and state. 1. It is the practice of the coassure that Sprinkler systemstalled in accordance wistandard. 2. An outside vendor has been contacted to replace yellow green color glass bulbs wittemperature rating of (155 in locations (a) Front Cove port, walkway and vestibut (b) kitchen, kitchen dry stostorage/water hoater room to kitchen. The required replacement a heads for above (a) and (b) be ordered and installed by vendor and thereby will reconded and installed by vendor and thereby will recovered in lint have been cled 1/09/12 and in good condition. The tamper slarm on the backovice for the sprinkler riser repaired by certified outside	onstitute te provider de or atement correction colely te law. Inter to the NFPA And the red degree F) the degree F) the command out the red degree F) the red degree F) the red the	01/23/13

STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GUA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	TIPLE CONSTRUCTION ONG 01 - MAIN BUILDING 01	(X3) DATE :	O930-03 SURVEY ETED
		345104	B. WING		4411	09/2012
	OVIDER OR SUPPLIER NURSING & REHA	BILITATION-ZEBULON	1.	TREET ADDRESS, CITY, STAYE, ZIP CODE 509 W GANNON AVE ZEBULON, NC 27597	1 13/0	AI UAIU
(X4) ID PREFIX TAG	CONCH DEFICIENC	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
T E a n 1 s	dased on observa pproximately 8:00 oted:) The gate valve fo prinkler line does lectronically super	age 4 Is not met as evidenced by: Iton on Friday 11/9/12 at Am onward the following was or the anti-freeze charged Is not equipped with an Ivised tamper alarm.	K 061		prinkler uding ating as ids. Also, prinkler	
K 069 N SS=D C	2 CFR 483,70(a) FPA 101 LIFE SA ooking facilities ar	FETY CODE STANDARD re protected in accordance .6, NFPA 96	. K 069	6. Findings would be discussed monthly Performance Improvement Committee meeting. K 061	at Vement	12/21/13
8 ap no 1) op 42 K 144 NF SS≒F Ge un	ased on observation observation of the control of t	s not met as evidenced by: ion on Friday 11/9/12 at Am onward the following was at time of inspection was' not : FETY CODE STANDARD acted weekly and exercised nutes per month in PA 99. 3.4.4.1.	K 144	1. It is the practice of the center that automatic sprinkler system valves with an electronically stamper alarm to be in compliant. 2. An outside vendor has been on for new gate valve equipped welectronically supervised tamp. The electronically supervised alarm has been ordered by the vendor thereby will request for extension. 3. Newly installed tamper alarm tested quarterly by the contract to be in NFPA compliance. 4. The Director of Plant Operation.	m have supervised: nec. ontacted rith an er alarm. tamper outside r a 30 day will be ted vendor	01/23/13
<u></u>	s STANDARD s -89) Frevious Versions Ol	not met as evidenced by:		monitor all quarterly inspection outside vendor and findings wil discussed in center's monthly P Improvement Committee meetly	s by I be erformance	

2012-13-04 09:04 DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 01 - MAIN BUILDING 01 B. WING 345104 NAME OF PROVIDER OR SUPPLIER 11/09/2012 STREET ADDRESS, CITY, STATE, ZIP CODE KINDRED NURSING & REHABILITATION-ZEBULON 509 W GANNON AVE ZEBULON, NC 27597 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PREFIX JO. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 5 K 144 K 144 K 069 Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was It is the practice of the center to assure 12/21/12 that kitchen hood is operational at all 1) The generator when tested did not transfer times. load within 10 seconds, 2. An outside vendor has been contacted 42 CFR 483.70(a) to replace the motor of the kitchen hood, the hood is now fully operational. 3. The Director of Plant Operation will make weekly rounds to ensure the kitchen hood is fully operational. 4. Findings will be discussed in center's monthly Performance Improvement Committee meeting. K 144 An outside Vendor has been contacted to install new Transfer Switch for the 12/21/12 generator. The generator will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA. 3. An audit would be performed by Plant Operations Manager weekly to record the transfer time of the generator with allow time 10 seconds, 4. Findings of the audit would be presented to monthly Performance Improvement Committee meeting.