PRINTED: 12/07/2012 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 345500	A. BUII B. WN	ILDIN	IPLE CONSTRUCTION DE CONSTRUCT	COMPLET	
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1221 BROAD STREET FUQUAY VARINA, NC 27526		0/201-
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROMDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323 SS≖G	HAZARDS/SUPERVI	ISION/DEVICES ure that the resident as free of accident hazards	F	323	Plan of Correction to the extent summary of findings is factually in order to maintain compliance applicable release provisions of The Plan of Correction is submit written allegation of compliance Point's response to the Stateme Deficiencies and Plan of Correcti denote agreement with the Stat Deficiencies, nor does it constituted admission that any deficiency is	oroposes this that the correct and e with the residents. tted as a e. Windsor ent of tion does not tement of ute an s accurate.	
	by: Based on record review facility failed to use a stransfer which resulted	iew and staff interviews, the mechanical lift during a ed in an injury for 1 of 4 led residents reviewed for			Further, Windsor Point reserves submit documentation to refute stated deficiencies on the Stater Deficiencies through informal di resolution, formal appeal procesany other administrative or lega	e any of the ment of lispute ess, and/or,	I
		mitted to the facility on tive diagnoses of spinal cord hritis.			F.323	·	
	(MDS) dated 11/6/12 was totally dependent	ssion Minimum Data Set indicated that Resident #11 ton staff for transfers. verely impaired in cognition.			Windsor Point will ensure the se provided or arranged by the faci professional standards of quality	cility will meet	
	dictates the type of sponeeds) dated 10/24/12	nt Care Guide (a form which pecialized care each resident 2 showed a mechanical lift mation for Resident #11.			I. Corrective action will be accorded for Resident #11 found to have affected by the deficient practic 1. On 11/28/12 the Director of the close of the contract of the contr	been ce as follows: of Nursing	
		sion Nursing Assessment ed a non-weight bearing I1.			checked all resident care cards f and also checked all resident's r ensure Hoyer Lift signs were in p	rooms to place.	
	Review of the Weekly	Nursing Summaries dated			II. Corrective action will be according for all residents having potential		

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

If continuation sheet Page 1 of 4

Facility ID: 958929

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345500	B. WIN	G		1	1/29/2012
	ROMDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 121 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE
	10/31/12, 11/2/12, an Resident #11 needed specialized mechanic lifted by the staff. Review of the Nurses 5:30 PM showed Nurse #1 had received a large of during a transfer from Bright red blood was and pressure was app #1. Emergency Medic called. Review of the Nurses 5:40 PM indicated the removal of pressure fr assessment a 3 inch to laceration (cut) was not calf by Nurse #1. The Resident #11 was transfer Emergency Department Review of the Nurses 7:45 PM showed that I information from the E had received stitches (the wound. Review of the Nurses I 9:30 PM showed Resident #30 PM showed PM showed Resident #30 PM s	d 11/7/12 indicated that I to be transferred using a al lift and not physically Notes dated 11/3/12 at sing Assistant (NA) #1 had to report that Resident #11 skin tear to the right leg the bed to a wheelchair. noted dripping onto the floor biled to the wound by Nurse al Services (EMS) was Notes dated 11/3/12 at arrival of EMS and the om the wound. On by 3 inch "V" shaped bed to Resident #11's right wound was bandaged and esported by EMS to the int (ED). Notes dated 11/3/12 at Nurse #1 received D staff that Resident #11 10) to the right calf to close Notes dated 11/3/12 at lent #11 was returned to	F	323	follows: 1. On 11/28/12 the Director checked all resident care card and also checked all resident' make sure Hoyer Lift signs we 2. On 11/30/2012 the Direct counseled NA #1 on the follow to locate a resident's activity "Accidents, Care Cards, Signal Activity Levels." NA #1 was to check at the beginning of his resident's activity transfer stated in the focusing on "Accidents, Care and Resident Activity Levels." 3. In-service for staff was be focusing on "Accidents, Care and Resident Activity Levels." 3. Directed in-service training he held from December 2012 2013. The in-service training and address supervision to professed by The Division of Fregulation and involves trans and accidents or falls involving problems. The approved DV "Mobility and Safe Movemen Improving Skills to Reduce Fall. The systemic changes put that deficient practices will not the following systems changlemented: a. "Hoyer Lift Signs and Res Card" (EXHIBIT 3)	s for accuracy s rooms to re in place. tor of Nursing wing: Where level and ge and Reside also counsele er shift each tus. (EXHIB END AND AND AND AND AND AND AND AND AND A	nt d

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
İ			A. BUII				-
		348500	8. WING		11/2	1/29/2012	
WINDSO	ROMDER OR SUPPLIER R POINT CONTINUING CA			12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(XS) COMPLETION DATE
	herself from the bed to the note, NA #1 did note because there was not Resident #11's bed. In an interview on 11/2 stated that Resident # mechanical lift for tran 10/24/12. She indicate (Resident Care Guide Living (ADL) book to s resident needed. NA # the facility when Resident had been informed mechanical lift would be an interview on 11/2 stated that Resident # and needed a mechan #1 indicated that this wworking with Resident the transfer information the resident's closet, of and also in the assignment that NA #1 should have in the areas provided of providing care to Resident in an interview on 11/2 stated she would look in Resident Care Guide to one or two people to as needed a mechanical lindicated the Resident checked by the aide at	o a wheelchair. According to be use the mechanical lift of mechanical lift sign over 28/12 at 2:26 PM NA #2 11 had needed a sfer since admission on ad there was a card of in the Activities of Daily how what assistance each 12 stated she had been at lent #11 had been admitted do at that time that a be needed for transfers. 19/12 at 9:27 AM Nurse #1 11 was non-weight bearing ical lift for transfers. Nurse 1/2 Nurse #1 stated that in was available hanging in in the Resident Care Guide ment book. She indicated a looked for the information or asked the nurse prior to lent #11 if she was not int. 19/12 at 11:22 AM NA #3 in the closet and on the coset and on the coset and on the coset if a resident needed isist with transfers. She Care Guide should be the beginning of the shift or care had been made. NA	F	323	 IV. Performance correcting the deficiencies will be monitored the following methods. A QA monitors has been put in place to assure the systems are in place. 1. The systems check "Hoyer Life Resident Care Cards" will be commanded as follows: a. Daily until 100% compliance weekly x 4, monthly x 3 and rand thereafter. (EXHIBIT 3) b. All findings will be reported V. January 31, 2013 	rough the toring tool he following ift Signs and apleted and is reached, lomly	1 31 2013

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		COMP		(X3) DATE S COMPL		
		345500	B. WIN	G			44	/29/2012	
	ROVIDER OR SUPPLIER	ARE		1221 BR	DRESS, CITY, STATE, ZIP CODE OAD STREET Y VARINA, NG 27526				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOUL	D 8E	(X5) COMPLETION DATE	
	mechanical lift for transitudinal interview on 11/2 indicated she would low which was kept at the Resident Care Guide twas needed for transfer #11 had been a mechanission. In an interview on 11/2 Rehabilitation Manage been a mechanical lift He indicated Resident not bear weight on her In an interview on 11/2 indicated that Resident removed. The wound wand monitored by the number of Nursing (DC expectation that aides of Guide, look in the assignessidents requiring mechanism for direction prior Multiple attempts over the suited services in the suited for the suited for the suited for the suited for direction prior Multiple attempts over the suited for the sui	29/12 at 11:42 AM NA #4 bok in the assignment book nursing station or on the to see if special equipment ers. She stated Resident anical lift transfer since 29/12 at 1:18 PM the r stated Resident #11 had transfer since admission. #11 was weak and could legs. 9/12 at 1:49 PM Nurse #2 t #11's stitches had been was still being bandaged tursing staff.	F	323					

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 345500 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1221 BROAD STREET WINDSOR POINT CONTINUING CARE **FUQUAY VARINA, NC 27526** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Windsor Point acknowledges receipt of K 000 INITIAL COMMENTS Statement of Deficiencies and proposes this Plan of Correction to the extent that the This Life Safety Code(LSC) survey was summary of findings is factually correct and conducted as per The Code of Federal Register in order to maintain compliance with the at 42 CFR 483.70(a); using the Existing Health applicable release provisions of residents. Care section of the LSC and its referenced The Plan of Correction is submitted as a publications. This building is Type III written allegation of compliance. Windsor construction, two story, with a complete automatic Point's response to the Statement of sprinkler system. Deficiencies and Plan of Correction does not denote agreement with the Statement of The deficiencies determined during the survey Deficiencies, nor does it constitute an admission that any deficiency is accurate. are as follows: K 018 Further, Windsor Point reserves the right to NFPA 101 LIFE SAFETY CODE STANDARD K 018 submit documentation to refute any of the SS=E stated deficiencies on the Statement of Doors protecting corridor openings in other than Deficiencies through informal dispute required enclosures of vertical openings, exits, or resolution, formal appeal process, and/or, hazardous areas are substantial doors, such as any other administrative or legal proceeding. those constructed of 1% 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 K 018 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 Windsor Point will ensure the services provided or arranged by the facility will meet 19.3.6.3 are permitted. professional standards of quality. Roller latches are prohibited by CMS regulations I. Corrective action will be accomplished by in all health care facilities. Windsor Point to correct the deficient practice as follows: 1. An audit on all facility doors was completed on 12/20/12. Four doors were found to have door props: Dietary Manager's office, dry storage (Dietary), Director of Nursing's Office, MDS/Medical Records office. (EXHIBIT 1) This STANDARD is not met as evidenced by: 2. All door props were removed on Based on observations and staff interview at (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDIN		(X3) DATE S COMPL	
	ROVIDER OR SUPPLIER	345500 G CARE	B. Wil	STF	REET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526	12/2	20/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 018 K 052 SS=E	items were nonconinclude: managers were held open wit survey(kitchen). 42 CFR 483.70(a) NFPA 101 LIFE SA A fire alarm system installed, tested, arwith NFPA 70 Nation 72. The system hall and testing program	am onward, the following appliant, specific findings and dry storage room doors in a wooden wedge at time of AFETY CODE STANDARD in required for life safety is and maintained in accordance and Electrical Code and NFPA is an approved maintenance in complying with applicable FPA 70 and 72. 9.6.1.4		018	12/20/12. II. Windsor Point will identify oth safety issues having the potential to residents by the same deficient pracorrective action will be taken as for the same deficient pracorrective action will be taken as for the same deficient pracorrective action will be taken as for the same deficient pracorrective action will be taken as for the same deficient on 12/20/12. Four do found to have door props: Dietar Manager's office, dry storage (Dietar Director of Nursing's Office, MDS/N Records office. (EXHIBIT 1) 2. All door props were removed of 12/20/12. III. The measures/systemic change into place so that deficient practice recur will be: 1. Facility managers and employed in-serviced not to prop open any displacements.	o affect actice and collows: as ors were y ary), Medical on ges put es will not	
K 056 SS=E	Based on observation approximately 8:30 litems were noncorrinclude: smoke del transmit a visual/al normal power. 42 CFR 483.70(a) NFPA 101 LIFE S/ If there is an auton installed in according the sign of the si	is not met as evidenced by: tions and staff interview at am onward, the following appliant, specific findings sector's and pull station did not udible signal with loss of AFETY CODE STANDARD attic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to	К	056	any time. (EXHIBIT 2) IV. Performance correcting these deficiencies will be monitored thro following methods: 1. The systems check "Propping Mechanism Audit" will be complet audited as follows: a. Dally until 100% compliance is weekly x 4, and randomly thereafte (EXHIBIT 1) V. January 31, 2013	ed and reached,	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LE CONSTRUCTION O1 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
		345500	B. Wil	1G		12/2	0/2012
V	ROVIDER OR SUPPLIER R POINT CONTINUIN	G CARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 121 BROAD STREET JQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	IŲLD BE	(X5) COMPLETION DATE
K 056	building. The syste accordance with N Inspection, Testing Water-Based Fire supervised. There supply for the syste systems are equip	overage for all portions of the em is properly maintained in FPA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler ped with water flow and tamper a electrically connected to the	К	056	Windsor Point will ensure the serve provided or arranged by the facility professional standards of quality. I. Corrective action will be accome Windsor Point to correct the deficit practice as follows: 1. Fire alarm company was contained on 12/20/12 to ensure facility working audio/visual signal with a for loss of power.	y will meet nplished by lent acted and lity had	
K 062 SS=E	Based on observa approximately 8:30 items were noncor include: bedrooms storage within 18 in 42 CFR 483.70(a) NFPA 101 LIFE SA Required automatic continuously maint condition and are in periodically. 19.25, 9.7.5	is not met as evidenced by: tions and staff interview at am onward, the following inpliant, specific findings 31,32 and 54 closets has inches of sprinkler head. AFETY CODE STANDARD is sprinkler systems are sained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA is not met as evidenced by:	K	062	 Audio/visual signal with active loss of power was restored on 12/(EXHIBIT 3) Windsor Point will identify oth safety issues having the potential residents by the same deficient precorrective action will be taken as for 1. Fire alarm company was contarrived on 12/20/12 to ensure fact working audio/visual signal with a for loss of power. Audio/visual signal with active loss of power was restored on 12/(EXHIBIT 3) The measures/systemic charlinto place so that deficient practice recur will be: 	her life to affect ractice and follows: acted and ility had ctivation ation for /20/12.	
	approximately 8:30 items were noncor include: at time of	Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey no spare heads were in sprinkler box in riser room.			During routine/random fire a testing and drills, working audio/with activation for loss of power with a	visual signal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345500	B. Wii	NG		12/20/2012	
	ROVIDER OR SUPPLIER	IG CARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 062	Continued From pa	age 3	K	062	checked to ensure compliance. IV. Performance correcting thes deficiencies will be monitored threfollowing methods: 1. The systems check "Fire Alarm will be completed and audited as a a. Daily until 100% compliance is weekly x 4, and routinely/random thereafter. (EXHIBIT 5) V. January 31, 2013 K 056 Windsor Point will ensure the serv provided or arranged by the facilit professional standards of quality. I. Corrective action will be accom Windsor Point to correct the defice practice as follows: 1. Resident rooms were checked remedied on 12/20/12 to ensure a was 18 inches below sprinkler hea (EXHIBIT 6) 2. A facility walkthrough was cor 12/21/12 to ensure all storage was below sprinkler heads. (EXHIBIT II. Windsor Point will identify oth safety issues having the potential tresidents by the same deficient pracorrective action will be taken as for the same action action	rices y will meet and all storage ds. mpleted on s 18 inches 6) mer life to affect actice and	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	AULT	IPLE CONSTRUCTION	(X3) DATE S	
		ioustill to the state of the st	A BU	ILDIN	G 01 - MAIN BUILDING 01	COMPL	EIEU
	·	345500	B. Wil	NG_		12/2	20/2012
NAME OF PROVIDER OR SUPPLIER WINDSOR POINT CONTINUING CARE				1	REET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 082 SS=E	remedied of was 18 inci (EXHIBIT 6) 2. A facility 12/21/12 to below spring the latest spectral will be spectral will be spectral will be spectral with the latest spectral will be spectr	ity walkthrough was completed on o ensure all storage was 18 inches nkler heads. (EXHIBIT 6) leasures/systemic changes put to that deficient practices will not e: managers and employees were on proper storage throughout ure all storage was 18 inches kler heads). (EXHIBIT 2) mance correcting these will be monitored through the ethods: tems check "Proper Facility lit" will be completed and ollows: httl 100% compliance is reached, and randomly thereafter.	KO	056	practice as follows: 1. Sprinkler company was contacted 12/20/12 to replace missing sprinkle in sprinkler box located in wet sprink room. 2. Sprinkler company was contacted 12/20/12 to complete sprinkler obstitest. II. Windsor Point will identify other safety issues having the potential to residents by the same deficient practic corrective action will be taken as follows: 1. Sprinkler company was contacted 12/20/12 to replace missing sprinkler in sprinkler box located in wet sprink room. 2. Sprinkler company was contacted 12/20/12 to complete sprinkler obstratest. III. The measures/systemic changes into place so that deficient practices recur will be: 1. The systems check "Spare Sprink Head Audit" will be completed and at as follows: a. Daily until 100% compliance is reweekly x 4, and randomly thereafter. (EXHIBIT 8)	r heads der d on ruction life affect tice and ows: d on r heads ler d on ruction s put will not ler udited	
	I. Correcti	re action will be accomplished by			A sprinkler obstruction test will be completed at least every 5 years from scheduled test.	- 1	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A BU		IPLE CONSTRUCTION IG 01 • MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345500	B. Wi				
NAME OF PROVIDER OR SUPPLIER WINDSOR POINT CONTINUING CARE				STF 1	REET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526	12/2	20/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 062			K	062	IV. Performance correcting these deficiencies will be monitored throuse following methods: 1. The systems check "Spare Sprin Head Audit" will be completed and a as follows: a. Daily until 100% compliance is reweekly x 4, and randomly thereafter (EXHIBIT 8) 2. A sprinkler obstruction test will completed at least every 5 years from scheduled test. V. January 31, 2013	kler audited eached,	

continuation sheet