PRINTED: 01/24/2013

FID 0 5 2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING C B. WING 01/09/2013 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3905 CLEMMONS ROAD **CLEMMONS NURSING & REHAB CENTER** CLEMMONS, NC 27012 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID **LEACH CORRECTIVE ACTION SHOULD BE** PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) F 000 This Plan of Correction is the center's credible F 000 INITIAL COMMENTS allegation of compliance. Preparation and/or execution of this plan of correction No deficiencies were sited as a result of the does not constitute admission or agreement by the complaint investigation survey of 1/9/13. Event provider of the truth of the facts alleged or conclusions F 431 set forth in the statement of deficiencies. The plan of ID# IR9C11. 483.60(b), (d), (e) DRUG RECORDS, correction is prepared and/or executed solely because F 431 it is required by the provisions of federal and state law. LABEL/STORE DRUGS & BIOLOGICALS SS≃E The facility must employ or obtain the services of a licensed pharmacist who establishes a system F-431 of records of receipt and disposition of all 1.) How corrective action will be controlled drugs in sufficient detail to enable an 2-6-13 accomplished for the resident affected: accurate reconciliation; and determines that drug records are in order and that an account of all No resident experienced any adverse controlled drugs is maintained and periodically outcome as a result of the deficient reconciled. practices cited. The following corrective actions were taken: Drugs and biologicals used in the facility must be Unit 3 nurse cleaned the Unit 3 labeled in accordance with currently accepted medication refrigerator 1/9/2013. professional principles, and include the The accumulation of ice on all appropriate accessory and cautionary instructions, and the expiration date when affected refrigerators was removed by the maintenance assistant on 1/9/2013. applicable. On 1/9/2013 the Consultant In accordance with State and Federal laws, the Pharmacist provided confirmation facility must store all drugs and biologicals in that all medications stored in the Unit locked compartments under proper temperature 3 refrigerator were not adversely controls, and permit only authorized personnel to affected by temperature and cleared have access to the keys. as acceptable for use. Unit 3 refrigerator was evaluated by The facility must provide separately locked, the Maintenance Director and found permanently affixed compartments for storage of to have a bad compressor. That controlled drugs listed in Schedule II of the refrigerator was discarded and Comprehensive Drug Abuse Prevention and replaced with a clean, new, frost free Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit refrigerator for storage of Unit 3 package drug distribution systems in which the medications on 1/9/2013. quantity stored is minimal and a missing dose can

LABORATORY DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE DMINISTRATOR

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.

be readily detected.

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

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		345131	B. WIN				C 0/2042
	ROVIDER OR SUPPLIER		<u> </u>	35	EET ADDRESS, CITY, STATE, ZIP CODE 905 CLEMMONS ROAD LEMMONS, NC 27012	1 0170	9/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	This REQUIREMENT by: Based on observation record reviews, the factorrect temperature of for 1 of 3 medication of facility failed to remove 3 medication refrigeration unit#3). The facility faill cutter and pill crus (Unit 2). The facility faill cutter and pill crus (Unit 2).	is not met as evidenced ns, staff interviews, and cility failed to maintain the f the medication refrigerator refrigerators (Unit#3). The re the build up of ice in 3 of stors (Unit#1, Unit#2 and siled to maintain a sanitary ther on 1 of 3 nursing unit ailed to maintain the inside sanitary manner in 1 of 3	F	431	 All pill cutters and crushers Medication-Carts were clear thoroughly by Medication A 1/9/2013. Unopened Novolog 70/30 fle Resident #139 was discarded DON on 1/9/2013. Unit 1, 2, and 3 nurses prese 1/9/2013 were educated by the or Unit Coordinator on facility policies and procedures relaproper storage of medication as cleanliness of medication refrigerators and pill cutters/crushers. No further discrepancies were not thoroughly contact the second contact of the second cont	ned xides on x pens for l by the ent on he DON lity ting to as as well	2-6-13
•	1/9/13 at 10:35 AM re 2 Novolog (insulin) 70 open and needed to be the manufactures inst unopened pens must Observation of the cle 2 's cart revealed drie cutting steel portion. To accumulation of black the crusher. Interview #1 was conducted on Medication Aide# 1 re pill cutter and crusher. The medication givers	be refrigerated. Pear portable pill cutter on unit bed residual on and near the life pill crusher had an substance at the base of with the Medication Aide 1/9/13 at 10:54 AM. The vealed, "I just cleaned the at 10:30 AM on 1//9/13.			 2.) How corrective action will be accomplished for those residents the potential to be affected: All residents are potentially affect medication storage temperature and cleanliness of refrigerators a cutters/crushers. Nurses and Mediation Aides to be in-serviced by the DON Unit Coordinator on the faci procedure for cleaning of refrigerators and pill cutter/and the facility infection content. 	having cted by control and pill continue I and lity crushers,	

FORM CMS-2587(02-99) Previous Versions Obsolete

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

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C 01/09/201	13
	(EACH DEFICIENC	CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	TREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE CO	(X5) WPLETION DATE
F 431	Observation of the m 1/9/13 at 11:14 AM th revealed an accumulapproximately 3-4 ind at this time with the M that the 3rd shift staff cleaning and defrosti Observation with Nur on 1/9/12 at 1:14 PM the medication refrige measured 58 degree dried dark brown and freezer compartment numerous dried dark inside the refrigerator the refrigerator unit h Interview on 1/9/15 a with Nurse#2 indicate responsible for clean refrigerator. Observation of the U refrigerator conducte revealed the freezer accumulation of ice r inches in thickness. I PM with Nurse #4 re responsible for the cl refrigerator. A staff interview was 1:37 PM with the ma he had not received inaccurate temperate	edication refrigerator on lat was located on Unit #2 ation of ice build up othes in thickness. Interview Medication Aide #1 indicated was responsible for any the refrigerator. se#2 and Medication aide#3 revealed the temperature of cerator on the 300 Unit is Fahrenheit. Numerous if golden colored spills in the were observed along with golden spills on the shelves or door. The freezer portion of ad a loud roaring sound. It the time of the observation is and defrosting the init One medication don 1/09/12 at 1:24 PM component had an ineasuring appropriately 2 interview on 1/9/12 at 1:27 interview on 1/9/13 at interview on 1/9/13 at interview of the 300 hall or nor the need for defrosting	F 43	policy. In-services to be c February 6, 2013. The Pharmacy Consultan and found refrigerator ter in compliance on 1/14/201 Medication Storage QA n tool was created on 1/14/2 monitors Unit Nurse weel compliance with temperar refrigerator cleanliness & and pill cutter/crusher cle On 1/15/2013 a new tempsheet was implemented th interventions taken when medication refrigerator is improper temperature, so an ice build-up. 3.) What measures will be put systemic changes made to ens correction: Medication Storage requirem services for staff will be conduparterly. The DON or designee will cor random visual audits per wee pill cutters/crushers are being facility policy using the Medic Storage QA Audit Tool. This Tool will also document comp	t checked inperatures 3. ionitoring 013. Tool cly ure logs, ice buildup, anliness. erature log at includes a found with iled or has in place or ure ent in- ucted at least inplete three k to ensure g cleaned per eation QA Audit	6-13

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Event ID: 1R9C11

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

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	IULTIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
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		345131	" ' ' ' ' ' '		01/0	19/2013
ŧ	ROVIDER OR SUPPLIER NS NURSING & REHAB (CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3905 CLEMMONS ROAD CLEMMONS, NC 27012	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 431	on 01/09/13 at 1:39 P member #5 indicated responsible to check tunit every 2 weeks. An interview with a Housekeeping staff m never been asked to defigerator on the 100 A staff interview was of Maintenance Manage. The Maintenance Mar 3rd day on the job and procedures. The mai indicated he was developed and clear the defrosting and clear An interview was conducted the Administrator (DON). The DON indicated to maintain the refriger temperature and her necessions.	sekeeper #5 was conducted M. Housekeeping staff housekeeping was the refrigerator on the 300 busekeeping staff member 01/09/13 at 1:45 PM. ember #6 revealed she had defrost the medication 0 or 200 hall. conducted with the ron 01/09/13 at 1:50 PM. hager stated this was his d not sure of the facility intenance manager eloping new environmental at there was no schedule for aning of the refrigerators. Stucted on 1/9/13 at 4:55 PM and the Director of Nurses cated her expectation was rators at the correct light shift nurses were refrigerator temperatures.	F	medication refrigerator temperature logs and iconfirme per week for ito then once per week for ito then once per week followed by once may achieved. Any discrepancies will bon and corrections in Facility staff will be edinglication Storage and Policies at least quarter 4.) How the facility plan performance to make stare ensured: Audit results will be revanalyzed monthly for the quarterly at t	ce build-up. s will be done three four weeks; c for three weeks; conthly until the ermines ance has been be noted by the nade accordingly. acated on d Infection Control ely. as to monitor its are that solutions viewed and aree months and uality Assurance h any subsequent ed and ed. The Director	2-6-13

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Ag Faddon 2/1/2013

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	·	FORM MAR 0 8 29MB NO.	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI	COMPLE	TED
		345131	B. WINO		1/2013
	ROVIDER OR SUPPLIER ONS NURSING & REI	IAB CENTER	}	reet address, city, state, zip code 3905 Clemmons road Clemmons, NC 27012	
(X4) ID PREFIX TAG	ADVICTORESCIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLEXIO
K 000			K 00	0	
K 018 \$S=D	at 42CFR 483.70(a Health Care section publications. This construction, one sautomatic sprinkle. The deficiencies of are as follows: NFPA 101 LIFE S. Doors protecting or required enclosure hazardous areas at those constructed wood, or capable minutes. Doors in required to resist to are provided with the door closed. If are permitted. Roller latches are in all health care for this STANDARD.	etermined during the survey AFETY CODE STANDARD corridor openings in other than es of vertical openings, exits, or are substantial doors, such as of 1½ inch solid-bonded core of resisting fire for at least 20 a sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping Dutch doors meeting 19,3.6.3.6 in prohibited by CMS regulations	K 01	This Plan of Correction is the center's credible allegation of compilance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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. K-018 (Bldg I) Basement storage case door padlocks removed. All storage areas inspected to ensure unapproved locks and hardware are not present. Documented environmental rounds and audits include an inspection for approved door locks and hardware. Response to requests for maintenance will be handled promptly. Plan of correction and environmental audits and results will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy.	April ZO 13

Any deficiency statement enging 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 44 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.

ng/2013/	PRI 05:05 PM		•			
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DEPARTN	MENT OF HEALT	H AND HUMAN SERVICES			OMB NO. 0	<u>938-0391</u>
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ATENIENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A BUILDING		OOK!! EDV	
DPLAKON	COMMESTION.		B. WING		02/21/	2013
		345131	1		1	
AME OF PR	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE 905 CLEMMONS ROAD		
-UEMMOI	NS NURSING & RE	HAB CENTER		LEMMONS, NG 27012		
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			16.040	K-020 (Bldg 1)	į	
K 018	Continued From s	page 1	K 018	V A buts on 100 hall (1st floor)	has been	1.11
	approximately 9:3	30 AM onward the following was		adjusted so it properly closes, latenes	and actual.	April'
	noted: 1) There are two storage cages located in the basement that are equipped with padlocks that would prevent an individual from exiting the		All facility vertical chutes are inspectively properly close, latch, and scal posterior	CT COUE.	2015	
1	would prevent an	IUQIAIGRSI IIOIII evinia nio		Documented environmental rounds a chute closing, latching, and sealing of	nd audits for completed	`
1	storage cage if lo	ocked.		I amakay Ance they Wick TOT IOUT WOU	V2 MIC CIA-	
	42 CFR 482.41(a)		monthly thereafter, Response to ten	uests for	
K 020	NFPA 101 LIFE	SAFETY CODE STANDARD	K 020	maintenance acted upon promptly. Plan of Correction and environment	al audits and	
ss≂D		tor shafts, light and ventilation		will be reviewed at the month	шy	
	1 //	AA AMDE VERRAN UDGURKY		performance improvement meeting compliance and consistency. The N	(QA) for	
	Labrage Soore 3	TO ANCIOSED WILL COLIST VOLUM		responsible for compliance with fac	ility policy.	
	having a fire resi	Istance rating of at least one may be used in accordance with				,
	8,2,5.6. 19.3.1	1.1.		K-029 (Bldg 1)		
				J durin nines	near laundry	1, 1
				chute discharge repaired to meet 100	e door near	April 2013
	This STANDAR	his STANDARD is not met as evidenced by:		fire resistant faining. Controls stored room 205 adjusted to properly close	, latch and	2013
	Based on obse	rvation on Thursday 2/21/2013 at :30 AM onward the following was		scal.		
	1 1 1.			Building swept and inspected to en pipe wall penetrations are scaled to		
	1) The laundry	chute door, on 1st floor, did not				1
	close; latch, and	a woul.	ł	inspected to ensure doors properly and seal per code. Corrections ma		1
	42 CFR 482.41	(a)	K 02	20dvanmental round	s and audits for	
K 029	. 1	SAFETY CODE STANDARD	1	this requirement 18 HIGG	W.C. COHO and	
S\$≓E	1 On a hour fire re	ated construction (with 1/4 hour		and documented by the Maintenar once per week for four weeks and	then once	
	fire-rated doors	yetem in accordance with 8.4.1		monthly thereafter.		
	10254	protects hazardous didas, vinoi)	Plan of Correction and environmed results will be reviewed at the me		
	I stand assertation a	HAMSEC LIE EXMIDAISHING STACH	1	i a improvement mecul	ייי נידע או)
	- (b = < 0.00000 h	the areas are separated from y smoke resisting partitions and		compliance and consistency. The responsible for compliance with		
	I seems Doores	ARA GAILCINGINII ANU SIULTIOISS SI		responsible for compilation water		1.
	field-applied pr	otective plates that do not exceed			If continuation s	heet Page 2
i	·			Facility ID: 923335	II CODUBRATION 3	

	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		•	ADJECTION .	PRINTED: 02. FORM APP OMB NO. 09 (X3) DATE SURVI COMPLETED	38-0391
muelit	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	JLTIPLE LDING	CONSTRUCTION 01 - MAIN BUILDING 01	02/21/2013	
		345131	B. WIN	•		UZIZIIA	013
	ROVIDER OR SUPPLIER		_l	3905	Y ADDRESS, CITY, STATE, ZIP CODE 3 CLEMMONS ROAD EMMONS, NC 27012		
(X4) ID PREFIX TAG	ONS NURSING & REI SUMMARY ST (EACH DEFICIENC REGULATORY OR	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	iX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	CHILD DC 1	(XS) OMPLETION DATE
K 029	Continued From p 48 Inches from the permitted. 19.3	e bottom of the door are	K	029			
K 04 SS=	Based on observapproximately 9:: noted: 1) The storage rote room 205, did 2) There are hole pipes, located not chute, that were the required fire 42 CFR 482.41 NFPA 101 LIFE Illumination of notice discharge, is an lighting fixture (darkness. (This lighting in accordance)	neans of egress, including exit ranged so that failure of any single bulb) will not leave the area in sides not refer to emergency redance with section 7.8.) 19.2.6	ie	K 045	on 100, 200 and 300 hall exits repl bulb fixtures. New light fixtures w lighting to the publicway and ensu surfaces are properly illuminated. Requirements for exit lighting and walk ways to parking lots were in ensure all other areas for the facilit same requirement. No other discre Documented environmental round include inspections for adequate of	will provide res the walking I illumination of vestigated to iny meet this repancies noted. ds and audits exit lighting will a Director once	April 7 2013
	Based on obs approximately noted: 1) Illumination discharge, is a lighting fixture	RD is not met as evidenced by: ervation on Thursday 2/21/2013 a 9:30 AM onward the following wan of means of egress including exarranged so that failure of any sin (bulb) will not leave the area in exit discharge lighting on the on 200 Hall, consisted of a one but	xit gle		be conducted by the transfer weekly for four weeks and month Plan of Correction and environm be reviewed at the monthly perform improvement meeting (QA) for consistency. The NHA is respondent to the compliance with facility policy.	ental rounds will ormance compliance and	

FORM CMS-2567(02-98) Provious Versions Obsolata

Event ID: 1R9C21

Facility ID: 923335

PRINTED: 02/27/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 B. WING 345131 02/21/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD **CLEMMONS NURSING & REHAB CENTER** CLEMMONS, NC 27012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE (X4) ID PREPIX PREFIX TAG TAG DEFICIENCY) K 045 Continued From page 3 K 045 fixture. Lighting must also be arranged to provide K-047 (Bldg 1) light from the exit discharge to the publicway (parking lot). Contractor hired on 3-6-2013. An exit sign and fire alarm pull station will be installed by The walking surfaces within the exit discharge contractor at the basement storage area exit door, shall be illuminated to values of at least 1 Installed light and pull station will be connected ft-candle measured at the floor. Fallure of any to emergency power circuits. single lighting unit does not result in an Complete facility was inspected and no other illumination level of less than 0.2 ft-candles in any locations were identified that were without the designated area, NFPA 101 7.8,1,1, 7,8,1,3, and appropriate exit signs or pull stations, per code. 7.8.1.4. No other discrepancies noted. Documented environmental rounds and audits 42 CFR 483.70(a) include inspections for operational exit signs and NFPA 101 LIFE SAFETY CODE STANDARD K 047 K 047 pull stations. These audits conducted once per SS≃D week for four weeks and then monthly thereafter. Exit and directional signs are displayed in Plan of Correction and environmental rounds will accordance with section 7.10 with continuous be reviewed at the monthly performance illumination also served by the emergency lighting improvement meeting (QA) for compliance and system, 19.2,10.1 consistency. The NHA is responsible for compliance with facility policy. This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at K-050 (Bldg 1) approximately 9:30 AM onward the following was Missing documentation for the fire drills noted: conducted on 1st shift 3rd quarter 2012 and 3rd shift 4th quarter 2012 could not be located. 1) An illuminated exit sign connected to emergency power is not provided at the exit door Second shift drill for 2012 could not be corrected - located on the storage side of the basement. for unexpected times. A review of procedures, method of record 42 CFR 482.41(a) retention, and scheduling of fire drills conducted K 050 to easure compliance with requirements for NFPA 101 LIFE SAFETY CODE STANDARD K 050 frequency and drill times being at unexpected SS#F times. Director of Environmental Services Fire drills are held at unexpected times under implements a tracking form for ensuring varying conditions, at least quarterly on each shift. compliance with documentation requirements, The staff is familiar with procedures and is aware that drills are part of established routine.

R/8/2013

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PRINTED: 02/27/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 02/21/2013 B. WING_ 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3905 CLEMMONS ROAD CLEMMONS, NC 27012 CLEMMONS NURSING & REHAB CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID PREFIX REGULATORY OR LOC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Wild K 050 Following each fire drill, the proper documentation of the drills along with the binders Continued From page 4 K 050 Responsibility for planning and conducting drills is that store this information are presented to the Administrator for signature signifying compliance assigned only to competent persons who are with these requirements. This signature serves as qualified to exercise leadership. Where drills are a cross check that this requirement is in conducted between 9 PM and 6 AM a coded announcement may be used instead of audible compliance. Plan of Correction and fire drill documentation 19,7.1.2 alarms. will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy. This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was K-051 (Bldg 1) Contractor hired for the installation of pull noted: 1) Upon review of the Fire Drill Documentation stations on 3-6-2013. An exit sign and fire alarm the 1st shift of the 3rd quarter of 2012 and the 3rd pull station with approved components, devices shift in the 4th quarter of 2012 were missing. and equipment will be installed at the basement 2) Upon review of the Fire Drill Documention the storage area exit door according to code. second shift fire dills for 2012 were within the Installed exit light and pull station will be same time frame. Fire drills are to held at connected to emergency power circuits, unexpected times under varying conditions, at Complete facility was inspected and no other least quarterly on each shift. locations were identified that were without the appropriate exit signs or pull stations, per code. No other discrepancies noted. 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 051 Documented environmental rounds and audits for K 051 assurance this requirement is met are conducted A fire alarm system with approved components, SS=D and documented by the Maintenance Director devices or equipment is installed according to once per week for four weeks and then once NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. monthly thereafter. Plan of Correction and environmental rounds will Activation of the complete fire alarm system is by be reviewed at the monthly performance manual fire alarm initiation, automatic detection or improvement meeting (QA) for compliance and extinguishing system operation. Pull stations in consistency. The NHA is responsible for patient sleeping areas may be omitted provided compliance with facility policy. that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are If continuation sheet Page 5 of 9

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Event ID; 1R9C21

Facility ID: 923335



PRINTED: 02/27/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 DENTIFICATION NUMBER: A. BUILDING 02/21/2013 B. WING 345131 STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD NAME OF PROVIDER OR SUPPLIER CLEMMONS, NC 27012 CLEMMONS NURSING & REHAB CENTER (XS) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) YAG DEFICIENCY) TAG K 051 Continued From page 5 K 051 maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 9.6 K-054 (Bldg 1) The HVAC unit in the basement area was shut down to open duct and expose smoke detector, The duct and smoke detector was cleaned and checked for proper operating according to manufacturer's specifications. On 3-6-2013 an annual inspection of the entire This STANDARD is not met as evidenced by: fire control system was conducted to include Based on observation on Thursday 2/21/2013 at checking of each fire detector in the facility. After one smoke detector was replaced all smoke approximately 9:30 AM onward the following was detectors were certified operating in accordance with manufacturer's specification. Continued 1) A Fire Alarm Pull Station is not provided at the scheduled inspections of the fire control system exit door in the basement - located near bulk will be conducted and results maintained for inspection. No other discrepancies noted. storage. Continued scheduled inspections of the fire 42 CFR 482,41(a) control system will be conducted and results K 054 NFPA 101 LIFE SAFETY CODE STANDARD maintained for inspection. Documented K 054 environmental rounds and audits include All required smoke detectors, including those ss=D inspections for smoke detectors and HVAC ducts activating door hold-open devices, are approved, to casure operations and they are clean by the maintained, inspected and tested in accordance Director of Maintenance. Rounds are documented with the manufacturer's specifications, 9,6,1,3 once per week for four weeks and monthly thereafter. Plan of Correction and environmental rounds will be reviewed at the monthly performance This STANDARD is not met as evidenced by: improvement meeting (QA) for compliance and Based on observation on Thursday 2/21/2013 at consistency. The NHA is responsible for approximately 9:30 AM onward the following was compliance with facility policy, 1) The duct smoke detector in the HVAC unit,

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located in the basement, is not maintained clean Event ID: 1R8C21

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R/Hallon 3/8/2013

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDENSUPPLIENCLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A BUILDING AND PLAN OF CORRECTION 02/21/2013 B. WING 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3905 CLEMMONS ROAD CLEMMONS, NC 27012 CLEMMONS NURSING & REHAB CENTER PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 054 Continued From page 6 K 054 and in good condition. 42 CFR 482.41(a) K 056 K-056 (Bldg 1) NFPA 101 LIFE SAFETY CODE STANDARD Sprinkler contractor was called to propose work K 058 required to correct deficiencies by installing SS=F If there is an automatic sprinkler system, it is sprinkler coverage to those areas cited. Parts installed in accordance with NFPA 13, Standard ordered and job awarded on 3-7-2013. for the Installation of Sprinkler Systems, to Sprinkler near the laundry chute is to be lowered provide complete coverage for all portions of the so as to not be obscructed by electrical conduit. building. The system is properly maintained in Sprinklers outside the activity storage area in the accordance with NFPA 25, Standard for the storage basement adjacent laundry is to be Inspection, Testing, and Maintenance of extended to provide coverage inside the storage Water-Based Fire Protection Systems. It is fully area. The wood framed walkway cover will have supervised. There is a reliable, adequate water sprinklers extended from building to provide supply for the system. Required sprinkler appropriate coverage into the framed cover. systems are equipped with water flow and lamper System will be able to withstand freezing temperatures. Sprinkler coverage is to be switches, which are electrically connected to the extended from the laundry into the wheelchair building fire alarm system. 19.3.5 storage room. Facility has been inspected thoroughly to ensure no other areas are uncovered by adequate sprinklers. Annual and all other scheduled inspections of the This STANDARD is not met as evidenced by: sprinkler systems will be documented and Based on observation on Thursday 2/21/2013 at maintained by the maintenance Director for review. Documented environmental rounds and approximately 9:30 AM onward the following was audits include inspections for sprinklers and sprinkler heads to ensure they are clean and 1) The sprinkler head located in front of the operational. Documented rounds once weekly for laundry chute discharge door - is installed above four weeks and monthly thereafter. and obstructed by the electrical conduits. 2) The activity storage unit in the basement did Plan of Correction and environmental rounds will not have complete sprinkler coverage. The wood be reviewed at the monthly performance improvement meeting (QA) for compliance and frame for the storage enclosure was blocking the sprinkler heads located outside of the storage consistency. The NHA is responsible for compliance with facility policy. area from providing coverage. 3) The wood framed covered walkway, located outside and between the two buildings, is not provided with sprinkler coverage. 4) The wheel chair storage area located under

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	/FRI 05:06 PM					PRINTED: 0	PROVED
EPARTI	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 0	938-0391
ENTERS	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLI	E CONSTRUCTION	COMPLETE	0.
TENENT (OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01 - MAIN BUILDING 01		
		345131				02/21/	2013
		UTO IV		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
	OVIDER OR SUPPLIER		- {	390	5 CLEMMONS ROAD		
LEMMO	NS NURSING & REF	AB CENTER		CL	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
	Continued From p	age 7 is accessible from outside, did	К	056	K-067 (Bldg 1) General contractor bired on 3-6-2013 the work required to install a high and combustion air inlet in the laundry.	to complete	April 9 2013
K 067 SS=D	not have sprinkler 42 CFR 462.41(a NFPA 101 LIFE S) AFETY CODE STANDARD			General contractor to install high and combustion air inlet in the laundry to provisions of section 9.2. Completio to DHSR deadline of April 7, 2013.	low meet n to be prior	
	with the provision	s of section 9.2 and are installed the manufacturer's 19.5.2.1, 9.2, NFPA 80A,			maintenance audits which include in new high and low combustion air inl conducted by the Maintenance Direct weekly for four weeks and monthly the conference of Correction and environments.	et will be tor once thereafter.	
	Based on obser approximately 9:) Is not met as evidenced by: vation on Thursday 2/21/2013 at 30 AM onward the following was			be reviewed at the monthly performance improvement meeting (QA) for communications. The NHA is responsible compliance with facility policy.	pliance and	
•	provided for the	y combustion air inlet is not gas fired dryers in the basement.	1		K-141 (Bidg 1&2) Oxygen cylinder found improperly 210 was removed, and no smoking Proper no smoking sign placed on Proper no smoking sign placed on	oxygen storago	Y'/
K 14	42 CFR 482.41 1 NFPA 101 LIFE	SAFETY CODE STANDARD		K 14	room doors located on 100 and 300	дши,	2015
SS=	Non-smoking ar where oxygen is with 19.3.2.4, N	and no smoking signs in areas used or stored are in accordance IFPA 99, 8.6.4.2. RD is not met as evidenced by:			Facility swept to locate all oxygen or used and to ensure all those loca approved non-smoking or no smok accordance with code. Staff in-ser conducted to re-educate staff on the for the proper use and location of smoking signs. Smoking free facility prohibit smoking on the outside of smoking area in a center courty are	ting sign in vice training e requirements aon- or no lity signs ty that also f any exit. Staff t is now	
	approximately s	gration on Thursday 22 9:30 AM onward the following wan ng sìgn is not provided at residen gen was found stored in the roon	t		prohibited. Documented environs and maintenance audits include in proper oxygen use and no smokin	spections for	sheet Page
1					Facility IO: 923335	it continuation	allent Labe

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ATGMENT	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	NG	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SUR' COMPLETE	Ð
		345131	1			02/21/	2013
ME OF PI	NOVIDER OR SUPPLIER		ST	3905	TADDRESS, CITY, STATE, ZIP CODE CLEMMONS ROAD		•
LEMMO	NS NURSING & REI	IAB CENTER		CLE	MMONS, NC 27012 PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLEXION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
K 141 Continued From 42 CFR 482.4 K 147 NFPA 101 LIF	- () - 1 widnes or	age 8) AFETY CODE STANDARD nd equipment is in accordance attonal Electrical Code. 9.1.2	K 14	to the	at re-educates staff on the requirement quirements for the use of non- or no gns. Documented environmental rot paintenance audits include inspection exygen use and no smoking signs. Row weekly for four weeks and monthly the with any discrepancies addressed imm	smoking unds and s for proper ounds done ercafter nediately.	April 7 2015
	This STANDARD Based on observ approximately 9:3 noted: 1) Throughout th missing there pro 2) The overhead machines is conr permanent wiring 3) There is a bit the ceiling and the	is not met as evidenced by: ation on Thursday 2/21/2013 at to AM onward the following was e basement the lights were tective covers for the bulbs, light in front of the washing nected by extension cord and not be wall junction between laundry ated in the basement. cord is being used in resident		PYY	Plan of Correction and results of envirounds will be reviewed at the month performance improvement meeting (compliance and consistency. The NI responsible for compliance with facility. K-147 (Bldg 1&2) General & electrical contractor contates to the following: Disconnect switch place Med-room refrigerators on emergency of the place Med-room refrigerators on emergency circuit, inspect all receptacles as required. Overhead light replaces delivered. Broken electrical conduit Cover is placed on junction box. Exand multi-plug receptacles removed. Sweep facility. Locate any extension multi-plug receptacles for removal contractor to sweep facility. Test all outlets, replace those that are broken receptacles with approved hospital (receptacles with approved hospital (receptacles). Electrical contractor with approved in the Stove from being turned on whe Electrical contractor to test all mediates to the stove from being turned on whe Electrical contractor to test all mediates are not. Sweep facility for all improperly installed or missing proceedings of the place those light fixtures with a overhead lighting. Environmental and maintenance reaudits will include inspections for damaged receptacles, overhead lighting.	connectal y (A) for (A) is ity policy. cted hired to on OT stove, argency and replace cents are is replaced, tension cords or Electrical is electrical is electrical is electrical is electrical in cracked, aergency grade ith install a that prevents on not in use. cation room the cry wire those coverhead lights becrive covers oproved ounds and approved or	April 70 13

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Event iD: 1R9C21



INTER:	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	(X3) P	ULTIP	LE CONSTRUCTION	(X3) DATE SUR COMPLETI	VET ED
rought (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ILDING		}	•
		345131	B, WI	_		02/21/	2013
ME OF PR	OVIDER OR SUPPLIER			99	EET ADDRESS, CITY, STATE, ZIP COD 05 CLEMMONS ROAD	Ē	
LEMMO	NS NURSING & RE	IAB CENTER		CI	PROVIDER'S PLAN OF COR	ECTION	COMPLETION
X4) ID REFIX TAG		NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRE TA	FIX	(EACH CORRECTIVE ACTION : (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
	INITIAL COMMEN	TS ode(LSC) survey was The Code of Federal Register		000	OT stove disconnect in use, and the usage of extension cords or multi-preceptacles. Rounds will be docum for four weeks and monthly thereal grade receptacles will be tension to by the Maintenance Department.	lug lug lented weekly fter, Hospital sted annually	April'
	at 42CFR 483.70(Health Care section publications. This construction, one automatic sprinkle	a); using the 2000 Existing on of the LSC and its reference building is Type III (111) story, with a complete or system.			Plan of Correction and results of environmental/maintenance rounds reviewed at the monthly performatimprovement meeting (QA) for co-consistency. The NHA is responsionable compliance with facility policy.	nco mpliance and	
K 012 SS=F	are as follows: NFPA 101 LIFE 5		1	⟨ 012	K-012 (Bldg 2) Ceiling/wall holes, texture, mold, been removed, sealed and/or repair	LEG ZDCCtyleses	
	1			where cited in Med rooms, exyge and the dictory office. Contractor and test all radiation dampers three for proper functioning. Repairs, v completed.	hired to clean oughout building where necessary,	April 7017	
	Based on obser approximately 9:) is not met as evidenced by; vation on Thursday 2/21/2013 30 AM onward the following v	vas		All med rooms and similar buildi to identify and correct similar buildi construction deficiencies. Damp clean all ducts, release and reset dampers for entire facility.	er contractor will radiation	
	300 Hall has hol sealed an maint 2) The radiation in the resident b	m located at the nurse station es in the ceiling that were not ained in good condition. dampers throughout the build athroom were not clean and and condition.	ding		Environmental and maintenance audits will include inspections for dampers and ducts being clean a by the Maintenance Director one weeks and monthly thereafter. I dampers placed on a four year re-	or radiation and be conducted be weekly for four cadiation betweeting schedule	4
	maintained in go growth on the co 4) The ceiling to storage room, o	on the sprinkler list footh was bod condition. There is mold eilling. exture in the hall near the oxy on 300 hall, is peeling and not	gen		Environmental construction con reviewed at the monthly perform improvement meeting (QA) for consistency. The NHA is respondent meeting the compliance with facility policy.	rance compliance and naible for	

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 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 program participation.

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	OMB NO. 0 (X3) DATE SUR COMPLETE	VEY
ID PLAN OF	CORRECTION	345131	B. WING		02 - BUILDING 02	02/21/	2013
	ROVIDER OR SUPPLIER			390	ET ADDRESS, CITY, STATE, ZIP CODE DE CLEMMONB ROAD EMMONS, NG 27012		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF)) TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE AGTION SHO CROSS-REPERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
K 012	office that were no good condition.	s in the ceiling in the Dietary It sealed and maintained in	Κ0	12			•
K 018 SS=D	Doors protecting of required enclosur hazardous areas those constructed wood, or capable minutes. Doors in required to resist no impediment to are provided with the door closed, are permitted.	corridor openings in other than es of vertical openings, exits, or are substantial doors, such as I of 1% inch solid-bonded core of resisting fire for at least 20 in sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping Dutch doors meeting 19.3.6.3.6 19.3.6.3		018	K-018 (Bldg 2) Medication room door tie down remonurse staff educated on requirements such actions. Unapproved barrel bol removed from 100 hall nurse station. Doors for rooms 104 & 107 adjusted properly close, latch and seal. All public and employee bathrooms ensure unapproved barrel locks are restaff in-serviced on Proper requirem procedures for doors closing where Building swept and inspected to ensure properly close, latch, and seal per out the seal per ou	inspected to bathroom. I so they inspected to bot present. I sents and required. I so they are doors before once thereafter. It be reviewed rement toonsistency.	Apr.11,
	Based on observations approximately 9 noted: 1) The corridor open - preventire	D is not met as evidenced by: rvation on Thursday 2/21/2013 at :30 AM onward the following was door to the Med Room was tied ng the door from being closed, was installed on the inside of the which required two motions of th					

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ENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	TX2\ MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLET	0938-0391 RVEY (ED
CTEMBAT I	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A BUILDIN			
		345131	1	700		/2013
	OVIDER OR SUPPLIER	AAR CENTER	3	LEET ADDRESS, CITY, STATE, ZIP O 905 CLEMMONS ROAD CLEMMONS, NG 27012	:00E ·	
LEMMO	NS NURSING & REF		10	PROVIDER'S PLAN OF C	ORRECTION	(X5) COMPLETION
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K 018		or to resident room 104 and	K 016			
K 025 SS=F	Smoke barriers a least a one half haccordance with terminate at an approtected by firepanels and steel separate compar floor. Dampers a penetrations of sheating, ventilating 19.3.7.3, 19.3.7.4 This STANDARI Based on observations of sheating, ventilating 19.3.7.4	re constructed to provide at our fire resistance rating in 3,3. Smoke barriers may brium wall. Windows are rated glazing or by wired glass frames. A minimum of two timents are provided on each re not required in duct moke barriers in fully ducted ing, and air conditioning systems. 5, 19,1.6.3, 19,1.6.4 D is not met as evidenced by: reation on Thursday 2/21/2013 at 30 AM onward the following was real in the affic on 300 Hall, has		Unapproved fire resistant foam attie removed and replaced wi grade scalant with approved fill facility fire walls and smo inspected to identify unapproved commercial grade, approved commercial grade, approved a pocumented environmental resourance this requirement is and documented by the Main once per week for four weeks monthly thereafter. Plan of correction and environments will be reviewed at the performence improvement to compliance and consistency, responsible for compliance of	ire sealant rating. ke barriers ved sealant foam. I foam replaced with fire resistant foam ounds and audits for met are conducted tenance Director s and then once ommental audits and the monthly the monthly the output of	2013
	holes and penel order to maintal rating of the wa	rations that were not soluted in the required fire resistance II. At the time of the survey it was hat unapproved foam sealant water and penetrations in the smok				

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TEMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDÍN	PLE CONSTRUCTION G 02 - BUILDING 02	(X3) DATE SUP COMPLET	RVEY ED
		345131				/2013
		HAB CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	3	PREET ADDRESS, CITY, STATE, ZIP COING CLEMMONS, NC 27012 PROVIDER'S PLAN OF COING (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RECTION	(X5) COMPLETION DATE
K 029	One hour fire rated construction (with ½ 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		K 029	K-029 (BIdg 2) 100 hall linen closet door was adjusted to properly close, latch and seal. Self closure device installed or adjusted on 300 hall clean linen door and 100 hall oxygen storage door. Contractor hired 3-7-2013 is to remove and replace doors between the kitchen and 100 dining room. Building swept and inspected to ensure all doors properly close, latch, and seal per code. Building swept to identify and install on doors requiring solf closure devices. Doors between the kitchen and dining room completely removed by contractor and replaced with new doors that properly close, latch and seal. Environmental and maintenance rounds and		April 2013
	Based on observapproximately 9:3 noted: 1) The clean line room 318 was not open with a linen 2) The doors between did not clos 3) The linen clos not have positive 4) The corridor on 100 Hall was device.	 The clean linen room corridor door next to room 318 was not self closing and was blocked open with a linen cart. The doors between the kitchen and the dining room did not close, latch and seal. The linen closet corridor door on 100 hall did not have positive latching The corridor door to the oxygen storage room on 100 Hall was not equipped with a self closing 		audits will include inspections for closing, latching and sealing. The conducted by the Maintenance E weekly for four weeks and month Environmental audits and results at the monthly performance improceing (QA) for compliance and The NHA is responsible for confacility policy.	r doors properly less will be irector once thy thereafter. will be reviewed rovement d consistency.	
K 038 SS≃F	Full coners is at	a) SAFETY CODE STANDARD ranged so that exits are readily times in accordance with section	Ko	38		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION							VEY D	
OF DESICIENCIES (A) PROVIDENTIAL PROVIDENTIA				(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - BUILDING 02				
NO PLAN OF CORRECTION		IDENTIFICATION NOME					02/21/2013	
		345131	B, WING			1 VENEZIA		
	an almolica			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		•	
NAME OF PR	OVIDER OR SUPPLIER	, 		38	05 CLEMMONS ROAD EMMONS, NC 27012			
CLEMMON	NS NURSING & REF		JD.	1		CTION	COMPLETION	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX 3	PROVIDER'S PLAN OF CORRECTION SHE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DAYE	
K 045 SS=F	Continued From page 4			038	K-038 (Bldg 2) Nurse staff training conducted that inc purpose and how to operate the maste switch for releasing the mag-locks on	doors.	April 7	
	This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was noted: 1) The staff when question were not familiar with the master override switch for the mag lock door.				Staff from all departments received in included the purpose and how to open master override switch for releasing to locks on doors.	the mag- facility	April 7	
					Annual training will be included on a training calendar for staff from all de receive training that includes the pur how to operate the master override s releasing the mag-locks on doors.	pose and witch for		
	NFPA 101 LIFE	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit		K 045	5 Plan of Correction will be reviewed monthly performance improvement for compliance and consistency. The responsible for compliance with factors and the second second second second second second second second second sec	ne NHA is		
	discharge, is arranged so that raise the area in				K-045 (Bldg 1&2)			
		does not refer to emergency lance with section 7.8.) 19.2.8			One bulb light fixtures for exit corr on 100, 200 and 300 hall exits repla- bulb fixtures. New light fixtures w lighting to the public way and ensur- numbers are properly illuminated.	ill provide res the walking	,	
	This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 a approximately 9:30 AM onward the following war noted: 1) Illumination of means of egress including ex discharge, is arranged so that failure of any sing lighting fixture (bulb) will not leave the area in darkness. The exit discharge lighting on the corridor exit on 300 and 100 hall consisted of a one bulb fixture. Lighting must also be arrange to provide light from the exit discharge to the publicway (parking lot).				Requirements for exit lighting and walk ways to parking lots were invensure all other areas for the facility area requirement. No other discre	ty meet this epancies noted.	- 1	
					Documented environmental round include inspections for adequate e be conducted by the Maintenance weekly for four weeks and month.	Director once ly thereafter.		
					Plan of Correction and environme be reviewed at the monthly perfor improvement meeting (QA) for c consistency. The NHA is respon- compliance with facility policy.	ompliance and		
		urfaces within the exit discharge nated to values of at least 1			F-1774 ID: 923335	If continuation	sheet Page 5 c	

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Facility ID: 923335



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PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES 02 - BUILDING 02 IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 02/21/2013 B. WING 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3805 CLEMMONS ROAD GLEMMONS, NC 27012 CLEMMONS NURSING & REHAB CENTER PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X4) ID TAG DEFICIENCY PREFIX TAG K 045 K 045 | Continued From page 5 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0,2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. K 052 | K-052 (Bldg 2) 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Fire alarm contractor bired and order placed for K 052 replacement parts for the fire control panel A fire alarm system required for life safety is SS=F designed to correct this deficiency. installed, tested, and maintained in accordance Annual fire system inspection completed on 3-6with NFPA 70 National Electrical Code and NFPA 2012. Results showed the system performed all 72. The system has an approved maintenance operational functions properly. Parts to replaced and testing program complying with applicable in the fire control panel that corrects the sited requirements of NFPA 70 and 72. deficiency. Visual and audible signals will now be available bringing the fire system into compliance with code. No other discrepancies noted Maintenance checks of the audible and visual signal cited will now be inspected as an element of each fire drill conducted. Outside inspectors continuo to scheduled maintenance and operational inspections of the fire control system. Those reports are maintained by the Maintenance Director. Environmental and maintenance rounds This STANDARD is not met as evidenced by: and audits will also include inspections for fire Based on observation on Thursday 2/21/2013 at system functionality. These will be conducted by approximately 9:30 AM onward the following was the Maintenance Director once weekly for four weeks and monthly thereafter noted: 1) Upon testing the Fire Alarm Control Panel Plan of Correction and environmental rounds will (FACP), there is no visual signal provided with be reviewed at the monthly performance loss of telephone line connection. improvement meeting (QA) for compliance and 2) Upon testing the (FACP) there is no visual and consistency. The NHA is responsible for audible alarm signals with loss of battery power. compliance with facility policy. 42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD K 058 K 056 If there is an automatic sprinkler system, it is SS≃F

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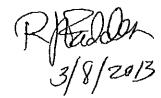
PRINTED: 02/27/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBERS AND PLAN OF CORRECTION A BUILDING 02 - BUILDING 02 B. WING 02/21/2013 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3905 CLEMMONS ROAD CLEMMONS NURSING & REHAB CENTER CLEMMONS, NC 27012 COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG DEFICIENCY) TAG K 056 K-056 (Bldg 2) K 056 | Continued From page 6 Removed all over spray from sprinkler head in Installed in accordance with NFPA 13, Standard Room 308 by Maintenance Assistant. for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the Remainder of sprinkler heads in the facility inspected to identify which (if any) required building. The system is properly maintained in cleaning to meet NFPA guidelines. Any sprinkler accordance with NFPA 25, Standard for the head noted as not being clean is scheduled to be Inspection, Testing, and Maintenance of cleaned by maintenance staff. Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water Environmental and maintenance rounds and audits will include inspections for dirty sprinkler supply for the system. Required sprinkler systems are equipped with water flow and tamper heads. These will be conducted by the Maintenance Director once weekly for four weeks switches, which are electrically connected to the and monthly thereafter. building fire alarm system. 19,3,5 Plan of Correction and environmental rounds will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy. This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at K-072 (Bldg 2) approximately 9:30 AM onward the following was Lifts in front of the exit door near therapy room on 300 hall relocated to meet standard that means noted: 1) There is overspray on the sprinkler heads in of egress are continuously maintained free of resident room 308 from the textured celling spray. obstructions in case of fire or emergency. Lifts in front of the exit door near dining room on 100 hall relocated to meet standard that means of 42 CFR 482.41(a) K 072 NFPA 101 LIFE SAFETY CODE STANDARD egress are continuously maintained free of K 072 obstructions in case of fire or emergency. SS=F Means of egress are continuously maintained free Staff in-service training conducted to re-educate of all obstructions or impediments to full instant staff on the requirements for maintaining means use in the case of fire or other emergency. No of egress free of obstructions. Documented furnishings, decorations, or other objects obstruct environmental rounds and maintenance audits exits, access to, egress from, or visibility of exits. include inspections to ensure means of egress art maintained free of obstructions. 7.1.10 In-service training is conducted semi-annually that re-educates staff on the requirements for maintaining means of egress free of obstructions. Environmental and maintenance rounds and This STANDARD is not met as evidenced by: audits will include inspections for ensuring means Based on observation on Thursday 2/21/2013 at of egress are maintained free of obstructions.

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	
TATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:		(X2) MULT A BUILDIN	iple construction ng 02 - Building 02	COMPLE	TED	
		345131	B. WING_		02/2	02/21/2013
AME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DE	
	NS NURSING & REF	IVB CENTEB		9905 CLEMMONS ROAD		
EEMMU				GLEMMONS, NC 27012 PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOTAGE CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETI DATE
K 072	Continued From page 7 approximately 9:30 AM onward the following was		K 072	These will be conducted by the M. Director once weekly for four weekly thereafter.	r weeks and moduly	
	noted: 1) Lifts were stored	d in the corridor - in front of the by 300 Hall and at the 100 Hall		Plan of Correction and results of a rounds will be reviewed at the mo performance improvement meetin compliance and consistency. The responsible for compliance with f	at the monthly at meeting (QA) for acv. The NHA is	
	42 CFR 482.41(a)		K 070	K-076 (Bldg 2)		
K 076 SS=D	Medical gas stora	AFETY CODE STANDARD ge and administration areas are dance with NFPA 99,	Kun	Regulators and hoses found on oxygen cylinders in 100 hall oxygen storage room were removed and properly stored. Staff educated on proper storage of items in oxygen rooms.		
	3,000 cu.ft. are en separation. (b) Locations for s 3,000 cu.ft. are ve	e locations of greater than iclosed by a one-hour supply systems of greater than ented to the outside. NFPA 99		Staff in-service training conducted to re-educate staff on the requirements for not storing items on oxygen cylinders and where proper storage locations exist. Documented environmental rounds and maintenance audits include inspections of oxygen rooms to ensure oxygen cylinders remain clear of materials stored on them.		791
	This STANDARD Based on observapproximately 9:3	This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was noted: 1) In the oxygen storage closet on 100 hall regulators and hoses were found stored on top of the cylinders.		In-service training is conducted a that re-educates staff on the requisioning items on oxygen cylinder proper storage locations exist. Denvironmental rounds and maintainched inspections of oxygen rooxygen cylinders remain clear of on them. Rounds dono weekly fand monthly thereafter with any addressed immediately.	frements for not s and where ocumented enance audits oms to ensure 'materials stored or four weeks	
	noted: 1) In the oxygen segulators and hother cylinders. 42 CFR 482.41(a)			Plan of Correction and results of rounds will be reviewed at the m performance improvement meet compliance and consistency. The responsible for compliance with	onthly ng (QA) for e NHA is	
K 141 SS=D	NFPA 101 LIFE	SAFETY CODE STANDARD	K 14	41	·	
	l Montemoking and	d no smoking signs in areas used or stored are in accordance				ļ

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 02 - BUILDING 02 A BUILDING B. WING 02/21/2013 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3905 CLEMMONS ROAD **CLEMMONS NURSING & REHAB CENTER** CLEMMONS, NG 27012 COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG K-141 (Bldg 1&2) K 141 K 141 | Continued From page 8 Oxygen cylinder found improperly stored in room 210 was removed, and no smoking signs posted. with 19.3.2.4, NFPA 99, 8.6.4.2. Proper no smoking sign placed on oxygen storage room doors located on 100 and 300 halls. Facility swept to locate all oxygen that is stored or used and to ensure all those locations have an This STANDARD is not met as evidenced by: approved non-smoking or no smoking sign in Based on observation on Thursday 2/21/2013 at accordance with code. Staff in-service training approximately 9:30 AM onward the following was conducted to re-educate staff on the requirements noted: for the proper use and location of non- or no 1) A no smoking sign is not provided on the smoking signs. Smoking free facility signs oxygen storage room doors - located on 100 and posted at all entrances to the facility that also probibit smoking on the outside of any exit. Staff 300 Hall. smoking area in a center courtyard is now prohibited. Documented environmental rounds 42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD and maintenance audits include inspections for K 144 proper oxygen use and no smoking signs SS=D Generators are inspected weekly and exercised In-service training is conducted semi-annually under load for 30 minutes per month in that re-educates staff on the requirements for the accordance with NFPA 99. 3,4,4,1. requirements for the use of non- or no smoking signs. Documented environmental rounds and maintenance audits include inspections for proper oxygen use and no smoking signs. Rounds done weekly for four weeks and monthly thereafter with any discrepancies addressed immediately. Plan of Correction and results of environmental rounds will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is This STANDARD is not met as evidenced by: responsible for compliance with facility policy. Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was K-144 (Bldg 2) noted: Oxygen cylinder found improperly stored in room 1) The generator annunicator panel was 210 was removed. Proper no smoking sign indicating a low battery voltage trouble for the 2013 placed on oxygen storage room doors located on generator and was also verified by maintenance 100 and 300 halls. at the time of the survey. Facility swept to locate all oxygen is stored or used and to ensure all those locations have an 42 CFR 482.41(a) approved non-smoking or no smoking sign in

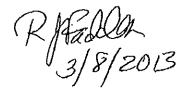
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K 147 NFPA 101 LIFE SAFETY CODE STANDARD

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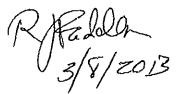
FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 02 B. WING 02/21/2013 345131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3905 CLEMMONS ROAD **CLEMMONS NURSING & REHAB CENTER CLEMMONS, NC 27012** COMPLETION COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES id Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY accordance with code. Staff in-service training conducted to re-educate staff on the requirements Continued From page 9 K 147 for the use of non- or no smoking signs. SS=F Documented environmental rounds and Electrical wiring and equipment is in accordance maintenance audits include inspections for proper with NFPA 70, National Electrical Code, 9.1.2 oxygen use and no smoking signs. In-service training is conducted semi-annually that re-educates staff on the requirements for the requirements for the use of non- or no smoking This STANDARD is not met as evidenced by: signs. Documented environmental rounds and Based on observation on Thursday 2/21/2013 at maintenance audits include inspections for proper oxygen use and no smoking signs. Rounds done approximately 9:30 AM onward the following was weekly for four weeks and monthly thereafter noted: with any discrepancies addressed immediately. 1) The stove in in Therapy was not equipped with a disconnect switch that would prevent the unit Plan of Correction and results of environmental from being turned on when not in use. rounds will be reviewed at the monthly 2) There were two broke duplex receptacles performance improvement meeting (QA) for compliance and consistency. The NHA is located between two resident beds - at the head responsible for compliance with facility policy. of the beds. Approve hospital grade receptacles will need to be installed where required. 3) Two unapproved non grounded receptacles were installed next to the beds in resident room K-147 (Bldg 1&2) 117. Approved receptacles will need to be General & cleenical contractor contacted hired to installed where required. do the following: Disconnect switch on OT stovo, 4) Throughout 100 hall cracked and unapproved place Med-room refrigerators on emergency duplex receptacles were found installed. power circuit, inspect all receptacles and replace 5) The emergency receptacles located in the hall as required. Overhead light replacements are on 100 hall were not approved receptacles. delivered. Broken electrical conduit is replaced. Cover is placed on junction box. Extension cords 6) The Junction box located in the dining room in and multi-plug receptacles removed the storage area along the kitchen wall was missing the box cover. Sweep facility. Locate any extension cords or 7) The Med refrigerator located on 100 half was multi-plug receptacles for removal. Electrical not connected to emergency power. contractor to sweep facility. Test all electrical 8) The lights in the Med room on 100 hall were outlets, replace those that are broken, cracked, non-grounded or not approved as emergency missing there protective covers for lights. receptacles with approved hospital grade 9) Multi plug receptacle adapters were found in receptacles. Electrical contractor will install a resident rooms on 100 hall. disconnect switch for the OT stove that prevents the stove from being turned on when not in use. Electrical contractor to test all medication room 42 CFR 482.41(a) refrigerators for being connected to the

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K-147 (Blog Z) (cont.)

cmergency power circuit, and properly wire those that are not. Sweep facility for all overhead lights improperly installed or missing protective covers. Replace those light fixtures with approved overhead lighting.

Environmental and maintenance rounds and audits will include inspections for approved or damaged receptacles, overhead lighting issues, OT stove disconnect in use, and the improper usage of extension cords or multi-plug receptacles. Rounds will be documented weekly for four weeks and monthly thereafter. Hospital grade receptacles will be tension tested annually by the Maintenance Department.

Plan of Correction and results of environmental/maintenance rounds will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy.

April 7 2013