STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were sited as a result of the complaint investigation survey of 1/9/13. Event ID # IR9C11.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *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.*	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	**F- 431** **1.) How corrective action will be accomplished for the resident affected:** 2-6-13 **No resident experienced any adverse outcome as a result of the deficient practices cited. The following corrective actions were taken:** • **Unit 3 nurse cleaned the Unit 3 medication refrigerator 1/9/2013.** • **The accumulation of ice on all affected refrigerators was removed by the maintenance assistant on 1/9/2013.** • **On 1/9/2013 the Consultant Pharmacist provided confirmation that all medications stored in the Unit 3 refrigerator were not adversely affected by temperature and cleared as acceptable for use.** • **Unit 3 refrigerator was evaluated by the Maintenance Director and found to have a bad compressor. That refrigerator was discarded and replaced with a clean, new, frost free refrigerator for storage of Unit 3 medications on 1/9/2013.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reginald J. Fadden

TITLE: ADMINISTRATOR

(X6) DATE: 2/1/2013

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.

JB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to maintain the correct temperature of the medication refrigerator for 1 of 3 medication refrigerators (Unit#3). The facility failed to remove the build up of ice in 3 of 3 medication refrigerators (Unit#1, Unit#2 and Unit#3). The facility failed to maintain a sanitary pill cutter and pill crusher on 1 of 3 nursing unit (Unit 2). The facility failed to maintain the inside of the refrigerator in a sanitary manner in 1 of 3 medication refrigerators. (Unit 300) Findings included: Observation of the Unit 2 ' s medication cart on 1/9/13 at 10:35 AM revealed Resident # 139 had 2 Novolog (insulin) 70/30 flex pens. One was not open and needed to be refrigerated. Review of the manufactures instructions revealed all unopened pens must be refrigerated. Observation of the clear portable pill cutter on unit 2 ' s cart revealed dried residual on and near the cutting steel portion. The pill crusher had an accumulation of black substance at the base of the crusher. Interview with the Medication Aide #1 was conducted on 1/9/13 at 10:54 AM. The Medication Aide# 1 revealed, " I just cleaned the pill cutter and crusher at 10:30 AM on 1//9/13. The medication givers and nurses are responsible for cleaning pill cutters and crusher after each use. "	F 431	• **All pill cutters and crushers on all Medication-Carts were cleaned thoroughly by Medication Aides on 1/9/2013.** • **Unopened Novolog 70/30 flex pens for Resident #139 was discarded by the DON on 1/9/2013.** • **Unit 1, 2, and 3 nurses present on 1/9/2013 were educated by the DON or Unit Coordinator on facility policies and procedures relating to proper storage of medications as well as cleanliness of medication refrigerators and pill cutters/crushers.** **No further discrepancies were noted.** **2.) How corrective action will be accomplished for those residents having the potential to be affected:** **All residents are potentially affected by medication storage temperature control and cleanliness of refrigerators and pill cutters/crushers.** • **Nurses and Mediation Aides continue to be in-serviced by the DON and Unit Coordinator on the facility procedure for cleaning of refrigerators and pill cutter/crushers, and the facility infection control**	2-6-13

Reg Faddon 2/1/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 2 Observation of the medication refrigerator on 1/9/13 at 11:14 AM that was located on Unit #2 revealed an accumulation of ice build up approximately 3-4 inches in thickness. Interview at this time with the Medication Aide #1 indicated that the 3rd shift staff was responsible for cleaning and defrosting the refrigerator. Observation with Nurse#2 and Medication aide#3 on 1/9/12 at 1:14 PM revealed the temperature of the medication refrigerator on the 300 Unit measured 58 degrees Fahrenheit. Numerous dried dark brown and golden colored spills in the freezer compartment were observed along with numerous dried dark golden spills on the shelves inside the refrigerator door. The freezer portion of the refrigerator unit had a loud roaring sound. Interview on 1/9/15 at the time of the observation with Nurse#2 indicated housekeeping was responsible for cleaning and defrosting the refrigerator. Observation of the Unit One medication refrigerator conducted on 1/09/12 at 1:24 PM revealed the freezer component had an accumulation of ice measuring appropriately 2 inches in thickness. Interview on 1/9/12 at 1:27 PM with Nurse #4 revealed 11-7 nurses are responsible for the cleaning of the medication refrigerator. A staff interview was conducted on 01/09/13 at 1:37 PM with the maintenance worker revealed he had not received communication about the inaccurate temperatures of the 300 hall medication refrigerator nor the need for defrosting or cleaning of medication refrigerators.	F 431	**policy. In-services to be completed by February 6, 2013.** • **The Pharmacy Consultant checked and found refrigerator temperatures in compliance on 1/14/2013.** • **Medication Storage QA monitoring tool was created on 1/14/2013. Tool monitors Unit Nurse weekly compliance with temperature logs, refrigerator cleanliness & ice buildup, and pill cutter/crusher cleanliness.** • **On 1/15/2013 a new temperature log sheet was implemented that includes interventions taken when a medication refrigerator is found with improper temperature, soiled or has an ice build-up.** **3.) What measures will be put in place or systemic changes made to ensure correction:** **Medication Storage requirement in-services for staff will be conducted at least quarterly.** **The DON or designee will complete three random visual audits per week to ensure pill cutters/crushers are being cleaned per facility policy using the Medication Storage QA Audit Tool. This QA Audit Tool will also document compliance with**	2-6-13

Reg Faulkner 2/1/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 3 An interview with Housekeeper #5 was conducted on 01/09/13 at 1:39 PM. Housekeeping staff member #5 indicated housekeeping was responsible to check the refrigerator on the 300 unit every 2 weeks. An interview with a Housekeeping staff member #6 was conducted on 01/09/13 at 1:45 PM. Housekeeping staff member #6 revealed she had never been asked to defrost the medication refrigerator on the 100 or 200 hall. A staff interview was conducted with the Maintenance Manager on 01/09/13 at 1:50 PM. The Maintenance Manager stated this was his 3rd day on the job and not sure of the facility procedures. The maintenance manager indicated he was developing new environmental procedures and stated there was no schedule for the defrosting and cleaning of the refrigerators. An interview was conducted on 1/9/13 at 4:55 PM with the Administrator and the Director of Nurses (DON). The DON indicated her expectation was to maintain the refrigerators at the correct temperature and her night shift nurses were expected to check the refrigerator temperatures. Attempts to interview the night nurses were unsuccessful.	F 431	**medication refrigerator cleanliness, temperature logs and ice build-up.** • **These observations will be done three time per week for four weeks;** • **then once per week for three weeks;** • **followed by once monthly until the QA Committee determines substantial compliance has been achieved.** **Any discrepancies will be noted by the DON and corrections made accordingly. Facility staff will be educated on Medication Storage and Infection Control Policies at least quarterly.** **4.) How the facility plans to monitor its performance to make sure that solutions are ensured:** **Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with any subsequent plans of action developed and implemented as indicated. The Director of Nursing is responsible for overall compliance.**	2-6-13

Reg Fadden 2/1/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

MAR 0 8 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *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 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 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 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at	K 018	K-018 (Bldg 1) Basement storage cage 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 7 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Reginald J Fadden	Administrator	3/8/2013

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.

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 1 approximately 9:30 AM onward the following was noted: 1) There are two storage cages located in the basement that are equipped with padlocks that would prevent an individual from exiting the storage cage if locked. 42 CFR 482.41(a)	K 018	K-020 (Bldg 1) Laundry chute on 100 hall (1st floor) has been adjusted so it properly closes, latches and seals. All facility vertical chutes are inspected to ensure they properly close, latch, and seal per code. Documented environmental rounds and audits for chute closing, latching, and sealing completed monthly once per week for four weeks and then monthly thereafter. Response to requests for maintenance acted upon promptly.	April 7 2013
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. 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 laundry chute door, on 1st floor, did not close; latch, and seal.	K 020	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.	
K 029 SS=E	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029	K-029 (Bldg 1) Holes in ceiling around drain pipes near laundry chute discharge repaired to meet requirements for fire resistant rating. Corridor storage door near room 205 adjusted to properly close, latch and seal. Building swept and inspected to ensure all drain pipe wall penetrations are sealed to maintain proper fire resistance rating. Building swept and inspected to ensure doors properly close, latch, and seal per code. Corrections made as required. Documented environmental rounds and audits for assurance this requirement is met are conducted and documented by the Maintenance Director once per week for four weeks and then once monthly thereafter. 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 7 2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 48 inches from the bottom of the door are permitted. 19.3.2.1 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 storage room corridor door, located next to room 205, did not close; latch, and seal. 2) There are holes in the ceiling around the drain pipes, located next to the laundry discharge chute, that were not sealed in order to maintain the required fire resistance rating of the ceiling. 42 CFR 482.41(a)	K 029		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was noted: 1) Illumination of means of egress including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. The exit discharge lighting on the corridor exit, on 200 Hall, consisted of a one bulb	K 045	K-045 (Bldg 1&2) One bulb light fixtures for exit corridor lighting on 100, 200 and 300 hall exits replaced with two bulb fixtures. New light fixtures will provide lighting to the publicway and ensures the walking surfaces are properly illuminated. Requirements for exit lighting and illumination of walk ways to parking lots were investigated to ensure all other areas for the facility meet this same requirement. No other discrepancies noted. Documented environmental rounds and audits include inspections for adequate exit lighting will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. Plan of Correction and environmental rounds will be reviewed at the monthly perfonnance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy.	April 1 2013

R J Faddon 3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 3 fixture. Lighting must also be arranged to provide light from the exit discharge to the publicway (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 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. 42 CFR 483.70(a)	K 045	K-047 (Bldg 1) Contractor hired on 3-6-2013. An exit sign and fire alarm pull station will be installed by contractor at the basement storage area exit door. Installed light and pull station will be connected to emergency power circuits. Complete facility was inspected and no other locations were identified that were without the appropriate exit signs or pull stations, per code. No other discrepancies noted.	April 7 2013
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 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) An illuminated exit sign connected to emergency power is not provided at the exit door - located on the storage side of the basement.	K 047	Documented environmental rounds and audits include inspections for operational exit signs and pull stations. These audits conducted once per week for four weeks and then monthly thereafter. 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.	
K 050 SS=F	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.	K 050	K-050 (Bldg 1) Missing documentation for the fire drills conducted on 1st shift 3rd quarter 2012 and 3rd shift 4th quarter 2012 could not be located. Second shift drill for 2012 could not be corrected for unexpected times. A review of procedures, method of record retention, and scheduling of fire drills conducted to ensure compliance with requirements for frequency and drill times being at unexpected times. Director of Environmental Services implements a tracking form for ensuring compliance with documentation requirements.	April 7 2013

R J Faddis 3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 4 Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 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) Upon review of the Fire Drill Documentation the 1st shift of the 3rd quarter of 2012 and the 3rd shift in the 4th quarter of 2012 were missing. 2) Upon review of the Fire Drill Documention the second shift fire dills for 2012 were within the same time frame. Fire drills are to held at unexpected times under varying conditions, at least quarterly on each shift.	K 050	Following each fire drill, the proper documentation of the drills along with the binders that store this information are presented to the Administrator for signature signifying compliance with these requirements. This signature serves as a cross check that this requirement is in compliance. Plan of Correction and fire drill documentation will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy.	April 17 2013
K 051 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided 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	K 051	K-051 (Bldg 1) Contractor hired for the installation of pull stations on 3-6-2013. An exit sign and fire alarm pull station with approved components, devices and equipment will be installed at the basement storage area exit door according to code. Installed exit light and pull station will be connected to emergency power circuits. Complete facility was inspected and no other locations were identified that were without the appropriate exit signs or pull stations, per code. No other discrepancies noted. Documented environmental rounds and audits for assurance this requirement is met are conducted and documented by the Maintenance Director once per week for four weeks and then once monthly thereafter. 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.	April 17 2013

RF Faddis 3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 5 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. 19.3.4, 9.6	K 051	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 fire control system was conducted to include checking of each fire detector in the facility. After one smoke detector was replaced all smoke detectors were certified operating in accordance with manufacturer's specification. Continued scheduled inspections of the fire control system will be conducted and results maintained for inspection. No other discrepancies noted.	April 7 2013
K 054 SS=D	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) A Fire Alarm Pull Station is not provided at the exit door in the basement - located near bulk storage. 42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 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) The duct smoke detector in the HVAC unit, located in the basement, is not maintained clean	K 054	Continued scheduled inspections of the fire control system will be conducted and results maintained for inspection. Documented environmental rounds and audits include inspections for smoke detectors and HVAC ducts to ensure operations and they are clean by the Director of Maintenance. Rounds are documented once per week for four weeks and monthly thereafter. 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.	

R Fadden 3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 054	Continued From page 6 and in good condition. 42 CFR 482.41(a)	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 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 sprinkler head located in front of the laundry chute discharge door - is installed above and obstructed by the electrical conduits. 2) The activity storage unit in the basement did not have complete sprinkler coverage. The wood frame for the storage enclosure was blocking the sprinkler heads located outside of the storage 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	K 056	K-056 (Bldg 1) Sprinkler contractor was called to propose work required to correct deficiencies by installing sprinkler coverage to those areas cited. Parts ordered and job awarded on 3-7-2013. Sprinkler near the laundry chute is to be lowered so as to not be obstructed by electrical conduit. Sprinklers outside the activity storage area in the storage basement adjacent laundry is to be extended to provide coverage inside the storage area. The wood framed walkway cover will have sprinklers extended from building to provide appropriate coverage into the framed cover. System will be able to withstand freezing temperatures. Sprinkler coverage is to be extended from the laundry into the wheelchair 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 sprinkler systems will be documented and maintained by the maintenance Director for review. Documented environmental rounds and audits include inspections for sprinklers and sprinkler heads to ensure they are clean and operational. Documented rounds once weekly for four weeks and monthly thereafter. 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.	April 7 2013

R Fadden
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 7 the walkway, that is accessible from outside, did not have sprinkler coverage. 42 CFR 482.41(a)	K 056	K-067 (Bldg 1) General contractor hired on 3-6-2013 to complete the work required to install a high and low combustion air inlet in the laundry.	April 7 2013
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 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) A high and low combustion air inlet is not provided for the gas fired dryers in the basement.	K 067	General contractor to install high and low combustion air inlet in the laundry to meet provisions of section 9.2. Completion to be prior to DHSR deadline of April 7, 2013. Documented environmental rounds and maintenance audits which include inspections for new high and low combustion air inlet will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. 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.	
K 141 SS=D	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. 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) A no smoking sign is not provided at resident room 210 - oxygen was found stored in the room.	K 141	K-141 (Bldg 1&2) Oxygen cylinder found improperly stored in room 210 was removed, and no smoking signs posted. 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 approved non-smoking or no smoking sign in accordance with code. Staff in-service training conducted to re-educate staff on the requirements for the proper use and location of non- or no smoking signs. Smoking free facility signs posted at all entrances to the facility that also prohibit smoking on the outside of any exit. Staff smoking area in a center courtyard is now prohibited. Documented environmental rounds and maintenance audits include inspections for proper oxygen use and no smoking signs	April 7 2013

R Fredden
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 141 K 147 SS=F	Continued From page 8 42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 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) Throughout the basement the lights were missing there protective covers for the bulbs. 2) The overhead light in front of the washing machines is connected by extension cord and not permanent wiring. 3) There is a broken electrical conduit located at the ceiling and the wall junction between laundry and storage - located in the basement. 4) An extension cord is being used in resident room 203. 42 CFR 482.41(a)	K 141 K 147	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 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 responsible for compliance with facility policy. K-147 (Bldg 1&2) General & electrical contractor contacted hired to do the following: Disconnect switch on OT stove, place Med-room refrigerators on emergency power circuit, inspect all receptacles and replace as required. Overhead light replacements are delivered. Broken electrical conduit is replaced. Cover is placed on junction box. Extension cords and multi-plug receptacles removed. Sweep facility. Locate any extension cords or multi-plug receptacles for removal. Electrical contractor to sweep facility. Test all electrical outlets, replace those that are broken, cracked, non-grounded or not approved as emergency receptacles with approved hospital grade receptacles. Electrical contractor will install a 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 refrigerators for being connected to the emergency 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,	April 17 2013 April 17 2013

R J Fredlon
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	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
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 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 Med Room located at the nurse station on 300 Hall has holes in the ceiling that were not sealed an maintained in good condition. 2) The radiation dampers throughout the building in the resident bathroom were not clean and maintained in good condition. 3) The ceiling in the sprinkler riser room was not maintained in good condition. There is mold growth on the ceiling. 4) The ceiling texture in the hall near the oxygen storage room, on 300 hall, is peeling and not maintained in good condition. 5) There are holes in the wall in the oxygen storage room that were not sealed.	K 012	K-012 (Bldg 2) Ceiling/wall holes, texture, mold, pealing have been removed, sealed and/or repaired specifically where cited in Med rooms, oxygen storage, halls and the dietary office. Contractor hired to clean and test all radiation dampers throughout building for proper functioning. Repairs, where necessary, completed. All med rooms and similar building areas swept to identify and correct similar building construction deficiencies. Damper contractor will clean all ducts, release and reset radiation dampers for entire facility. Environmental and maintenance rounds and audits will include inspections for radiation dampers and ducts being clean and be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. Radiation dampers placed on a four year re-testing schedule. Environmental construction condition 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reginald J. Faddis
TITLE: Administrator
(X6) DATE: 3/8/2013

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.

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 1 6) There are holes in the ceiling in the Dietary office that were not sealed and maintained in good condition. 42 CFR 482.41(a)	K 012		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 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 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 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 corridor door to the Med Room was tied open - preventing the door from being closed. 2) A barrel bolt was installed on the inside of the bathroom door which required two motions of the	K 018	K-018 (Bldg 2) Medication room door tie down removed and nurse staff educated on requirements forbidding such actions. Unapproved barrel bolt hardware removed from 100 hall nurse station bathroom. Doors for rooms 104 & 107 adjusted so they properly close, latch and seal. All public and employee bathrooms inspected to ensure unapproved barrel locks are not present. Staff in-serviced on Proper requirements and procedures for doors closing where required. Building swept and inspected to ensure doors properly close, latch, and seal per code. Environmental and maintenance rounds and audits will include inspections for doors properly closing, latching and sealing. These will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. 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.	Apr. 17 2013

R Faddis

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 hand to open the door. (Bathroom Nurse station 100 Hall) 3) The corridor door to resident room 104 and 107 did not close latch and seal. 42 CFR 482.41(a)	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 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 smoke wall in the attic on 300 Hall, has holes and penetrations that were not sealed in order to maintain the required fire resistance rating of the wall. At the time of the survey it was also observed that unapproved foam sealant was used to seal holes and penetrations in the smoke wall.	K 025	K-025 (Bldg 2) Unapproved fire resistant foam sealant in 300 hall attic removed and replaced with commercial grade sealant with approved fire sealant rating. All facility fire walls and smoke barriers inspected to identify unapproved sealant foam. Where identified, unapproved foam replaced with commercial grade, approved fire resistant foam. Documented environmental rounds and audits for assurance this requirement is met are conducted and documented by the Maintenance Director once per week for four weeks and then once monthly thereafter. 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 7 2013
K 029 SS=E	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

R J Faddis 3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was noted: 1) The clean linen room corridor door next to room 318 was not self closing and was blocked open with a linen cart. 2) The doors between the kitchen and the dining room did not close, latch and seal. 3) The linen closet corridor door on 100 hall did not have positive latching 4) The corridor door to the oxygen storage room on 100 Hall was not equipped with a self closing device. 42 CFR 482.41(a)	K 029	K-029 (Bldg 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 self 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 audits will include inspections for doors properly closing, latching and sealing. These will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. 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 7 2013
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

R Fedder
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 4 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.	K 038	K-038 (Bldg 2) Nurse staff training conducted that included the purpose and how to operate the master override switch for releasing the mag-locks on doors. Staff from all departments received training that included the purpose and how to operate the master override switch for releasing the mag-locks on doors. Annual training will be included on facility training calendar for staff from all departments to receive training that includes the purpose and how to operate the master override switch for releasing the mag-locks on doors.	April 17 2013
K 045 SS=F	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at approximately 9:30 AM onward the following was noted: 1) Illumination of means of egress including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. The exit discharge lighting on the corridor exit on 300 and 100 hall consisted of a one bulb fixture. Lighting must also be arranged to provide light from the exit discharge to the publicway (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1	K 045	Plan of Correction will be reviewed at the monthly performance improvement meeting (QA) for compliance and consistency. The NHA is responsible for compliance with facility policy. K-045 (Bldg 1&2) One bulb light fixtures for exit corridor lighting on 100, 200 and 300 hall exits replaced with two bulb fixtures. New light fixtures will provide lighting to the publicway and ensures the walking surfaces are properly illuminated. Requirements for exit lighting and illumination of walk ways to parking lots were investigated to ensure all other areas for the facility meet this same requirement. No other discrepancies noted. Documented environmental rounds and audits include inspections for adequate exit lighting will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. 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.	April 17 2013

R Faddis

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 045		
K 052 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 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) Upon testing the Fire Alarm Control Panel (FACP), there is no visual signal provided with loss of telephone line connection. 2) Upon testing the (FACP) there is no visual and audible alarm signals with loss of battery power.	K 052	K-052 (Bldg 2) Fire alarm contractor hired and order placed for replacement parts for the fire control panel designed to correct this deficiency. Annual fire system inspection completed on 3-6-2012. Results showed the system performed all operational functions properly. Parts to replaced in the fire control panel that corrects the sited 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 continue to scheduled maintenance and operational inspections of the fire control system. Those reports are maintained by the Maintenance Director. Environmental and maintenance rounds and audits will also include inspections for fire system functionality. These will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter 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.	April 7 2013
K 056 SS=F	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

R J Fedder
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 6 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 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) There is overspray on the sprinkler heads in resident room 308 from the textured ceiling spray.	K 056	K-056 (Bldg 2) Removed all over spray from sprinkler head in Room 308 by Maintenance Assistant. Remainder of sprinkler heads in the facility inspected to identify which (if any) required cleaning to meet NFPA guidelines. Any sprinkler head noted as not being clean is scheduled to be cleaned by maintenance staff. Environmental and maintenance rounds and audits will include inspections for dirty sprinkler heads. These will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. 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.	April 7 2013
K 072 SS=F	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Thursday 2/21/2013 at	K 072	K-072 (Bldg 2) Lifts in front of the exit door near therapy room on 300 hall relocated to meet standard that means of egress are continuously maintained free of 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 egress are continuously maintained free of obstructions in case of fire or emergency. Staff in-service training conducted to re-educate staff on the requirements for maintaining means of egress free of obstructions. Documented environmental rounds and maintenance audits include inspections to ensure means of egress are maintained free of obstructions. 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 audits will include inspections for ensuring means of egress are maintained free of obstructions.	April 7 2013

R Fedder
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 7 approximately 9:30 AM onward the following was noted: 1) Lifts were stored in the corridor - in front of the exit door at Therapy 300 Hall and at the 100 Hall Dining room exit door. 42 CFR 482.41(a)	K 072	These will be conducted by the Maintenance Director once weekly for four weeks and monthly thereafter. 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 responsible for compliance with facility policy.	April 7 2013
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: 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.	K 076	K-076 (Bldg 2) 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. 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. In-service training is conducted semi-annually that re-educates 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. 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 responsible for compliance with facility policy.	April 7 2013
K 141 SS=D	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance	K 141		

R Faddoul
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 141	Continued From page 8 with 19.3.2.4, NFPA 99, 8.6.4.2. 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) A no smoking sign is not provided on the oxygen storage room doors - located on 100 and 300 Hall. 42 CFR 482.41(a)	K 141	K-141 (Bldg 1&2) Oxygen cylinder found improperly stored in room 210 was removed, and no smoking signs posted. 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 approved non-smoking or no smoking sign in accordance with code. Staff in-service training conducted to re-educate staff on the requirements for the proper use and location of non- or no smoking signs. Smoking free facility signs posted at all entrances to the facility that also prohibit smoking on the outside of any exit. Staff smoking area in a center courtyard is now prohibited. Documented environmental rounds and maintenance audits include inspections for proper 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 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 responsible for compliance with facility policy.	April 17 2013
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 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 generator annunicator panel was indicating a low battery voltage trouble for the generator and was also verified by maintenance at the time of the survey. 42 CFR 482.41(a)	K 144		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	K-144 (Bldg 2) Oxygen cylinder found improperly stored in room 210 was removed. Proper no smoking sign placed on oxygen storage room doors located on 100 and 300 halls. Facility swept to locate all oxygen is stored or used and to ensure all those locations have an approved non-smoking or no smoking sign in	April 17 2013

R Faddis
3/8/2013

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING 02 - BUILDING 02 B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3805 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147 SS=F	Continued From page 9 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 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 stove in in Therapy was not equipped with a disconnect switch that would prevent the unit from being turned on when not in use. 2) There were two broke duplex receptacles located between two resident beds - at the head 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 117. Approved receptacles will need to be installed where required. 4) Throughout 100 hall cracked and unapproved duplex receptacles were found installed. 6) The emergency receptacles located in the hall on 100 hall were not approved receptacles. 6) The Junction box located in the dining room in the storage area along the kitchen wall was missing the box cover. 7) The Med refrigerator located on 100 hall was not connected to emergency power. 8) The lights in the Med room on 100 hall were missing there protective covers for lights. 9) Multi plug receptacle adapters were found in resident rooms on 100 hall. 42 CFR 482.41(a)	K 147	accordance with code. Staff in-service training conducted to re-educate staff on the 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. 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 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 responsible for compliance with facility policy. K-147 (Bldg 1&2) General & electrical contractor contacted hired to do the following: Disconnect switch on OT stove, place Med-room refrigerators on emergency power circuit, inspect all receptacles and replace as required. Overhead light replacements are delivered. Broken electrical conduit is replaced. Cover is placed on junction box. Extension cords and multi-plug receptacles removed. Sweep facility. Locate any extension cords or multi-plug receptacles for removal. Electrical contractor to sweep facility. Test all electrical outlets, replace those that are broken, cracked, non-grounded or not approved as emergency receptacles with approved hospital grade receptacles. Electrical contractor will install a 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 refrigerators for being connected to the	April 17 2013 April 17 2013

R Faddis
3/8/2013

K-147 (Bldg 2)
(cont.)

emergency 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.

April 2013

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.

R A Faddis
3/8/2013