STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide routine dental care for 1 of 1 sampled resident (Resident #97). Findings included: Resident # 97 was admitted to the facility on 2/15/2011 with diagnoses that included Anemia, Chronic Kidney Disease, Osteoarthritis, Vitamin B 12 Deficiency, and a history of Hypertension and Degenerative Joint Disease with Kyphosis. The most recent Quarterly Minimum Data Set (MDS) dated 3/13/2013 indicated that Resident #97 was cognitively intact, needed total assistance for hygiene, and only set up assistance for eating. Review of the Care Plan dated 2/15/2011 with revisions up to 1/13/2013 revealed a care deficit pertaining to teeth or oral cavity with a goal that the resident would be able to chew food	F 412	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Hughes — TITLE: Administrator — (X6) DATE: 4/23/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 412	Continued From page 1 sufficiently to swallow through the next review. Interventions included: 1. Instructing the resident in good oral hygiene 2. Monitoring and notifying the physician of signs or symptoms of oral/dental problems needing attention or possible evaluation including missing, loose, broken, eroded, or decayed teeth. 3. Providing good oral hygiene On 4/1/2013 at 4:54 pm Resident #97 stated in an interview that she had missing teeth which made it hard to chew. When asked if she had seen a dentist about the missing teeth, she stated that she had not seen a dentist since she came to the facility. Observation of Resident #97 found at least two missing teeth in the bottom front with one tooth that was leaning forward almost flat to the gum. Review of the medical record found no dental assessments or consults. The record also had no notes regarding Resident #97 having missing teeth or needing dental care. Physician's orders reviewed included an order dated 2/15/2011 for a mechanical soft diet. There were no orders for a dental consult. During an interview on 4/4/2013 at 10:39 am the MDS nurse stated that she was sure they had discussed seeing a dentist with Resident #97 and her family and they declined. Asked if she had any documentation to that effect, the MDS nurse said she would check the thinned records for documentation. At 11:05 am on 4/4/2013 the Social Worker stated in an interview that she remembered talking to Resident # 97 and her family and they	F 412	F412 1. Resident # 97 had dental appointment scheduled by Transportation Coordinator on 4/4/13 for 4/17/13 at 9 am. 2. 100% audit completed by administrative nursing staff of residents dental care needs by evaluation and interview with dental appointments scheduled for any appropriate residents completed by 4/15/13. 3. Licensed Nurses and Administrative Nursing staff inserviced by Staff Facilitator on evaluating dental care needs and scheduling dental appointments for residents on admission, with a significant change and annually by 4/25/13. Administrative nurses will evaluate for dental needs on new admissions, residents triggering as a significant change and with annual MDS using a dental care needs QI audit tool with appointment to be scheduled as appropriate.	5/2/13

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
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 412	Continued From page 2 didn't want her to see a dentist as her teeth had always been like that. She and the MDS nurse were unable to find any documentation of the discussion. On 4/4/2013 at 1:36 pm Resident # 97 was observed with ground chicken, greens, mashed potatoes, thickened juice and water, and fruit pie for lunch. She had eaten the mashed potatoes and a bite or two of chicken. Asked why she didn't eat more of the chicken and greens, she stated that she didn't have any back teeth and it was hard to chew with just front teeth. Resident #97 added that it took a long time to eat because of the missing teeth. Asked if she had ever had dentures, she said the teeth hadn't always been gone. She had pyorrhea and lost the teeth over time. Resident # 97 also said that a nurse asked her today if she wanted to get dentures and she said yes, she thought it would help her. In an interview at 2:02 pm on 4/4/2013 the Social Worker stated that in the past residents who were unable to transfer to a dentist's chair had to go to Chapel Hill for dental care. Chapel Hill was the only office that would take residents in either a wheel chair or a geriatric chair and it was very difficult and time consuming to get an appointment there. She said they offered to send Resident #97 to Chapel Hill and she didn't want to go. The Social Worker revealed that recently they had found a local dentist who would take residents in wheel chairs. Asked if they had made an appointment for Resident # 97 she said they had not since the family had indicated they didn't want the resident to see a dentist. The Social Worker also said there was no documentation of this offer or discussion with the family.	F 412	1. Administrative nurses will monitor dental care evaluation with appropriate appointment scheduled, complete on 25% of new admissions, significant changes and annual MDS weekly x 8 weeks, then monthly x 3 months. The Administrator will review the results of all audits to assure continued compliance in this area. Results of audits will be forwarded to the Executive QI committee to determine continued need for monitoring and frequency.	

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
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 412	Continued From page 3 On 4/4/2013 at 2:22 pm the Administrator stated in an interview that until the first of the year resident ' s who were wheel chair bound had to go to Chapel Hill for dental care and it was hard to get appointments for them. She said this year they did find a local dentist who would take residents in wheel chairs and they would get an appointment for resident #97. She also reported they had no documentation of a discussion with the resident or her family about going to Chapel Hill for dental care. At 2:30 pm on 4/4/2013, Resident # 97 when asked if the facility had offered to send her to Chapel Hill for dental care would she have been willing to go said yes. NA #1 stated in an interview at 2:37 pm on 4/4/2013 that Resident #97 didn't complain about anything. She indicated that Resident #97 had some trouble eating because of her teeth. NA #1 revealed that she gave mouth care daily with sponges and mouthwash. She occasionally gently used a toothbrush because of the way the teeth stuck out. At 2:40 pm on 4/4/2013 Nurse #1 stated that Resident #97 didn't complain about having trouble eating. She indicated that she had not noticed Resident # 97 having any difficulty eating or drinking on her current diet and did well on thickened liquids. During an interview at 5:30 pm on 4/4/2013 the Director of Nurses (DON) was asked what her expectations were for providing dental care to residents who needed dental care or dental	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 412	Continued From page 4 consults. The DON responded that if a resident could not get into a dental chair, they had to go to Chapel Hill for care and it took a long time to get appointments set up there. She added that recently a local dentist had been found who would provide dental care to residents who could not transfer to a dental chair. The DON stated that they were also trying to get all the resident's appointments that needed care. She concluded by saying there should have been a note to indicate that a resident's dental needs had been assessed and addressed even if the resident refused the care. Her expectations were that an appointment be made for a resident who needed dental care.	F 412		
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	F 431	F431 1. Expired drugs were removed by Director of Nursing from Emergency Drug Kit (EDK) in second floor nurse's station, first floor nurses station, and 39 hall medication administration cart on 4/4/2013. 2. All nurses stations, emergency drug kits, medication carts and treatment carts were inspected by Administrative Nurses for expired medications and expired medications removed on 4/8/2013.	5/2/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 5 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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from use in 3 of 8 medication storage areas. The findings include: 1. On 04/04/2013 an observation was conducted with staff member #1 of the 2nd floor nurse's station medication room. Observed on the cabinet was an unlocked/open Emergency Drug Kit (EDK). On the top area under the lid the following medications were observed and found to be expired: Phenytoin 100mg/ml lot # 031390 Expired 03/2013 (10 vials) Cefazolin 1 Gm lot # 101B014 Expired 03/13 (3 vials) Erythrocin tablets lot # 04120AF Expired 03/24/12 (20 individually wrapped tablets) On 04/04/13 at 1:15 p.m. Nurse # 2 was interviewed concerning the expired medications.	F 431	3. Inservices were provided by Staff Facilitator to licensed nurses and medication aides regarding the 5 R's of medication administration including checking expiration dates by 4/25/13. 4. Administrative nurses will audit all medication carts, emergency drug kits and treatment carts for expired medications with follow up taken as needed using a QI audit tool weekly x 8 weeks, then monthly x 3 months. The Administrator will review the results of all audits to assure continued compliance in this area. Results of audits will be forwarded to the Executive QI committee to determine continued need for monitoring and frequency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 6 Nurse # 2 indicated the medications were expired and but could not state why the expired medications were readily available for the nursing staff's use and had not been removed. An interview was conducted with the facility's Director of Nursing (DON) on 04/04/2013 at 5:38 p.m. concerning her expectations of ensuring expired medications are not readily available for use. The DON stated, "The expectation is nurse's check their carts prior to giving medications, the 3rd shift nurses are assigned to check the medication rooms and remove all expired medication so they will not be used." 2. On 04/04/2013 at 1:27 p.m. an observation was conducted with the facility's Director of Nursing (DON) of the medication administration cart for the 39 hall. The following medication was found to be expired: 1-opened/used 10cc vial of sterile water for injection lot# 21-513-DK Expiration date 09/01/15. The vial had an open date documented on the side indicating it was 1st used on 02/11/13. An interview with the DON indicated the opened/used vial should have been removed from use as the open/1st used date was over 30 days prior to the observation. The DON could not state why the medication had not been removed. The medication had been opened for 52 days from 1st use. An interview was conducted with the facility's Director of Nursing (DON) on 04/04/2013 at 5:38 p.m. concerning her expectations of ensuring expired medications are not readily available for use. The DON stated, "The expectation is nurse's	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 7 check their carts prior to giving medications, the 3rd shift nurses are assigned to check the medication rooms and remove all expired medication so they will not be used." 3. On 04/04/2013 at 2:40 p.m. an observation was conducted with the facility's Director of Nursing (DON) of the 1st floor medication room. On the cabinet an open plastic Emergency Drug Kit (EDK) was observed with the Director of Nursing (DON). The following medication was observed in the open top tray and found to be expired: Lorazepam tab lot # 111092 Expired 01/2013 (1 tab). The DON verified the medication was expired and could not state why the medication had not been removed, discarded, or returned to the pharmacy. An interview was conducted with the facility's Director of Nursing (DON) on 04/04/2013 at 5:38 p.m. concerning her expectations of ensuring expired medications are not readily available for use. The DON stated, "The expectation is nurse's check their carts prior to giving medications, the 3rd shift nurses are assigned to check the medication rooms and remove all expired medication so they will not be used."	F 431		

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
	345321	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This plan of correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 04/24/2013 the valves controlling the accelerator on the dry sprinkler system were not electrically supervised. 42 CFR 483.70 (a)	K 061 K061	1. On 5/2//2013, valves controlling the accelerator on the dry sprinkler system were corrected Sunland Fire Protection, Inc and Charles Taylor Electric to be electrically supervised. 2. All valves that should be electrically supervised were checked Sunland Fire Protection on 5/2/2013 and are monitored as required. 3. Maintenance Director will check when work is completed on sprinkler system by outside contractors to ensure all valves are electrically supervised as required. 4. On annual inspection, valves will be checked to ensure that they are electrically supervised as required.	6/10/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Stuckes | TITLE: Administrator | (X6) DATE: 5/7/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 1 protected construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 056 SS=D	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: A. Based on observation on 04/24/2013 the basement laundry chute area was not covered by the sprinkler system. 42 CFR 483.70 (a)	K 056	1. A sprinkler head will be installed in the basement laundry chute area on 5/14/13 by Sunland Fire Sprinkler, Inc. 2. Facility reviewed to ensure all areas are covered by sprinkler system. 3. Maintenance Director will check when work completed on facility by outside contractors to ensure all areas of facility remain covered by sprinkler system. 4. Annually facility will be reviewed to ensure all areas covered by sprinkler system.	6/10/2013
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are	K 076		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Hughes — TITLE: Administrator — (X6) DATE: 5/7/13

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.

CD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(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 076	Continued From page 1 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: A. Based on observation on 04/24/2013 there were full and empty 02 cylinders mixed inthe 02 storage room. 42 CFR 483.70 (a)	K 076	1. Maintenance Director separated full and empty oxygen cylinders in all oxygen rooms on 4/26/13. 2. The Staff Facilitator initiated staff inservices for all staff on not mixing full and empty oxygen cylinders in the oxygen storage rooms. 3. Maintenance Staff will monitor oxygen rooms once weekly x 4 weeks then monthly for three months using a QI audit tool with corrective measures as necessary. 4. Administrator will review the results of all audits to assure continued compliance in this area. Results of audits will be forwarded to the Executive QI committee to determine continued need for monitoring and frequency.	6/10/2013