STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING _____ B. WING _____	04/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 W PETTIGREW STREET DURHAM, NC 27705

(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 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities recertification and complaint investigation survey conducted on 04/03/13.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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
	345001	A. BUILDING 03 - HILLCREST CONVALESCENT CENTER B. WING _____	MAY 1 2013 04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 W PETTIGREW STREET DURHAM, NC 27705

(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 A. Based on observation on 04/25/2013 the facility is a two (2) story ,type 111 protected ,fully sprinklered and magnetic locks.	K 000	This plan of correction constitutes Hillcrest Convalescent Center, Inc.'s (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
K 038 SS=D	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. 18.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 04/25/2013 the staff interviewed did not know about the master door release switch at the nurses station. 42 CFR 483.70 (a)	K 038	[K 038] On or before May 3, 2013 the maintenance director or his designee conducted in-service education of all employees. These sessions included re-educating all employees where the master door releases are located and reviewing how to operate the releases.	5/3/13
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, 18.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 04/25/2013 02 cylinders were mixed in the 2nd. floor 02 storage room.	K 076	It should be noted that at no time were any master door releases identified as not working properly, and all employees questioned were already aware that any activated fire alarm pull station releases the magnetic doors. Also, all employees questioned were already aware that the release beside each magnetically locked door would also release the door. Beginning the week of May 6, 2013 the maintenance director or his designee will poll staff twice weekly for two weeks, once weekly for four weeks, and then periodically to ensure knowledge of the master door release switch at the nurses station. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for its effectiveness.	

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

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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
	345001	A. BUILDING 03 - HILLCREST CONVALESCENT CENTER B. WING _____	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 W PETTIGREW STREET DURHAM, NC 27705

(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 42 CFR 483.70 (a)	K 076	[K 076] On May 3, 2013 the director of nursing or her designee conducted in-service education of all employees. These sessions included educating all employees to not comingle an empty oxygen (O2) cylinder with full O2 cylinders. Employees were instructed to place empty O2 cylinders only in the outdoor storage area. Further inspections on the day in question and periodically since has proved that all additional O2 storage areas (and subsequently at the second floor O2 storage room) were conforming to regulations. Beginning the week of May 6, 2013 the director of nursing or her designee will observe O2 storage areas and poll staff twice weekly for two weeks, once weekly for four weeks, and then periodically to ensure the standards continue to be met. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for its effectiveness.	5/3/13