

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

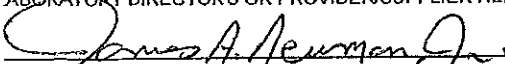
PRINTED: 06/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 0303 - REPLACEMENT BLDG B. WING _____	(X3) DATE SURVEY COMPLETED JUN 19 2013 06/05/2013
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NAME OF PROVIDER OR SUPPLIER WESTCHESTER MANOR AT PROVIDENCE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262
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(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)	(X6) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 10904 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 II (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
K 029 SS=D	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 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 10904 Based on observation on Wednesday 6/5/13 the following was noted: 1) The Central supply corridor door was found wedged open and would not close, latch and seal when the wedged was removed. 2) The corridor door doors to the soiled linen	K 029	K-029 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: The central supply corridor door along with the soiled linen doors on 200 and 400 halls were repaired to ensure that they would close, latch and seal properly. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will complete an audit of all facility doors to ensure they close, latch and seal properly. Repairs completed as indicated.	7/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6/17/13
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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.

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K 029 K 045 SS=E	<p>Continued From page 1 rooms located on 200 and 400 hall would not close latch and seal.</p> <p>42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Surveyor: 10904 Based on observation on Wednesday 6/5/13 the following was noted:</p> <p>1) At 100 Hall exit the exterior discharge lighting consisted of a single bulb fixture. 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</p> <p>2) The exit pathway leading from the sensory garden to the public way was not properly illuminated. Lighting must be arranged to provide light from the exit discharge leading to the public way (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.</p>	K 029 K 045	<p>3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete a monthly inspection of 25% of facility doors to inspect for proper closing, latching and sealing. Repairs will be completed as indicated.</p> <p>4. Indicate how the facility will monitor its performance: Results will be presented to Quality Assurance team for recommendations and follow up for 3 months.</p> <p>K-045</p> <p>1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: An additional fixture (bulb) was added to the 100 hall exit exterior. Additional lighting was placed in the sensory garden to provide proper illumination to the public way.</p>	7/20/13

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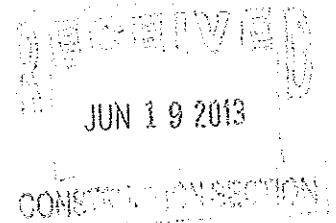
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K 045	Continued From page 2 42 CFR 483.70(a)	K 045	<ol style="list-style-type: none"> 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will complete an audit of all hall exit exteriors and pathways leading to public ways to ensure proper lighting in place. Additional lighting will be installed as indicated. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete a monthly inspection of exterior lighting to ensure proper functioning of fixtures with repairs or replacement as indicated. 4. Indicate how the facility will monitor its performance: Results will be presented to Quality Assurance team for recommendations and follow up for 3 months. 	



Providence Place™
Senior Health and Housing



June 17, 2013

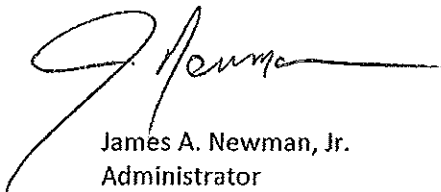
North Carolina Dept Health & Human Services
Division of Health Service Regulation
Construction Section
2705 Mail Service Center
Raleigh, NC 27699-2705

Dear Mr. Daniel,

Attached please find the completed Plan of Correction for the Life Safety Survey conducted on June 5, 2013. This Plan of Correction being submitted does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal Law. The facility alleges compliance as of July 20, 2013.

If you have any questions please contact me at the facility at 336-888-4601 or email me at jnewman@providenceplacenc.com

Sincerely,



James A. Newman, Jr.
Administrator



Living well every day.

Administrative Offices
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