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

PRINTED: 08/19/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
}					- 10-1000		С
345330			B. WNG		08/15/2013		
NAME OF P	ROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE		
ZUE OB ()	(SPIER WIRO & BETIRE	THENT OF		1	116 LANE DRIVE		
THE GRAT	BRIER NURS & RETIRE	MENICI		٦	TRINITY, NC 27370		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE
F 000		pliance with the FR Part 483, Subpart B for	F	000			
		lities. No deficiencies were e complaint investigation					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		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.

CENTERS FOR MEDICARE & MEDICAID SERVICES  BYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			DATE SURVEY COMPLETED		
		345330	B. WING		09/0	5/2013	
NAME OF PROVIDER OR SUPPLIER  THE GRAYBRIER NURS & RETIREMENT CT			STREET ADDRESS, CITY, STATE, ZIP CODE 116 LANE DRIVE TRINITY, NC 27370				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	9E	(X5) COMPLETIO DATE	
K 000	INITIAL COMMEN	тѕ	K 000	<u>K 025</u>			
	conducted as per T at 42 CFR 483.70(a Health Care section publications. This fa construction utilizin	ode (LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced acility is Type V (III) protected g North Carolina Special hts, and is equipped with a		All penetrations to smoke barriers the 1. smoke wall in the attic space near room number 31 and in the 2. smoke wall in the attic space at the administrative area were repaired approved fire rated caulk.		9-9-13	
K 025 SS=D	CFR#: 42 CFR 483,70 (a) NFPA 101 LIFE SAFETY CODE STANDARD		K 025	All other smoke barriers were chec to ensure there were no unsealed penetrations present.	ked	9-11-1	
	least a one half hot accordance with 8. terminate at an atriprotected by fire-rapanels and steel fra separate compartmitor. Dampers are penetrations of smootheating, ventilating,	soke barriers are constructed to provide at st a one half hour fire resistance rating in cordance with 8.3. Smoke barriers may minate at an atrium wall. Windows are steeted by fire-rated glazing or by wired glass nels and steel frames. A minimum of two parate compartments are provided on each or. Dampers are not required in duct metrations of smoke barriers in fully ducted ating, ventilating, and air conditioning systems. 3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4		The Maintenance Director and/or Maintenance Assistant will make monthly rounds to examine all smowalls to ensure there are no unseal penetrations. Any findings of unse penetrations will be corrected and recorded in the monthly maintenaring.	ed aled	9-11-1	
	This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 9/5/2013 the following item was observed as noncompliant, specific findings include: There were unsealed penetrations in the rated walls at the following locations.  1. smoke wall in the attic space near room number 31.			The Maintenance Director will util the "2013 Life Safety Plan of Correction Audit Tool" that has be developed to log all corrective actimonthly, if necessary. This report be reviewed at quarterly Quality Assurance meetings for six months.	on ions will	9-11-1	

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.

If continuation sheet Page 1 of 2

(X8) DATE

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

PRINTED: 09/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345330		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		B, WING			09/05/2013		
	PROVIDER OR SUPPLIER  AYBRIER NURS & RE	TIREMENT CT		STREET ADDRESS, CNY, STATE, ZIP CODE 118 LANE DRIVE TRINITY, NG 27370			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPT DEFICIENCY)			(X\$) OMPLETIO DATE	
K 025 Continued From page 1 administrative area.		-	K 025 <u>K 029</u>				
K 029	CFR#. 42 CFR 483.70 (a)		K 029	The buildup of dust and lint in combustion chamber of the gas dryers in the laundry was clean	fired	-9-13	
				There are no other combustion chambers for dryers in the laun therefore there are no other are would be affected.	dry,	9-13	
en e				The Maintenance Director and/ Maintenance Assistant will che and/or clean the combustion ch for the gas fired dryers in the la monthly. A housekeeping empl will be assigned to clean the	ck amber undry	9-9-13	
				combustion chamber weekly as directed by the Maintenance Di	rector.		
	include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry.  CFR#: 42 CFR 483.70 (a)		The Maintenance Director will the annual "Cleaning Schedule has been developed to log clear check dates, and initials of percleaning and checking the combenanter. This report will be reat quarterly Quality Assurance Meetings through the end of cayear 2014.	'that n dates, son(s) bustion viewed	)-11-1 <u>3</u>		

FORM CMS-2687(02-99) Previous Versions Obsoleto

Event ID: TFXO21

Facility IO: 953491

If continuation sheet Page 2 of 2



CENTE	RS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES	· •	PRINTED: 09/09/20  PRINTED: 09/09/20  PRINTED: 09/09/20  PRINTED: 09/09/20	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION GOI - MAIN BUILDING P 3 0 2013		
345330		B. WING	09/05/2013		
NAME OF PROVIDER OR SUPPLIER  THE GRAYBRIER NURS & RETIREMENT CT		STREET ADDRESSIOTH SECTION  116 LANE DRIVE  TRINITY, NC 27370			
(XA) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE DATE  DEFICIENCY) (X5) COMPLETION DATE	
K 000	INITIAL COMMENT	s	K 000	K 025	
	conducted as per That 42 CFR 483,70(a) Health Care section publications. This faconstruction utilizing	de (LSC) survey was ne Code of Federal Register ); using the 2000 Existing of the LSC and its referenced cility is Type V (III) protected North Carolina Special as, and is equipped with a sprinkler system.		All penetrations to smoke barriers in the 1. smoke wall in the attic space near room number 31 and in the 2. smoke wall in the attic space at the administrative area were repaired with approved fire rated caulk.	
K 025 SS≒D		70 (a) ETY CODE STANDARD constructed to provide at	K 025	All other smoke barriers were checked 9-11-13 to ensure there were no unsealed penetrations present.	
	least a one half hour accordance with 8.3. terminate at an atriur protected by fire-rate panels and steel fran separate compartme floor. Dampers are no penetrations of smok	r fire resistance rating in  . Smoke barriers may m wall, Windows are ed glazing or by wired glass nes. A minimum of two ents are provided on each not required in duct to barriers in fully ducted and air conditioning systems.		The Maintenance Director and/or Maintenance Assistant will make monthly rounds to examine all smoke walls to ensure there are no unsealed penetrations. Any findings of unsealed penetrations will be corrected and recorded in the monthly maintenance log.	
o vili	Based on the observiouring the tour on 9/5 vas observed as non- nclude: There were the rated walls at the	attic space near room		The Maintenance Director will utilize the "2013 Life Safety Plan of Correction Audit Tool" that has been developed to log all corrective actions monthly, if necessary. This report will be reviewed at quarterly Quality Assurance meetings for six months.	

9-30-13

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