

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

PRINTED: 10/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337		
(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 (General Health Survey). Event NNMN11.	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

PRINTED: 11/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2013
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 209 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337	
(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. Building 0102 and 0202 is Type III construction, one story, with a complete automatic sprinkler system. The census at the time of the survey was 82.	K 000		
K 067 SS=D	The deficiencies determined during the survey are as follows: 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: 42 CFR 483.70(a) By observation on 11/20/13 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant; specific findings include the emergency shut down switch located at a readily observed station did not function properly.	K 067	RECEIVED DEC 06 2013 CONSTRUCTION K 067 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). The emergency shut down switch located at the readily observed station was repaired on 12/2/2013 to function properly in accordance with the manufacturer's specifications. The Maintenance Director will monitor the emergency shut down switches on a weekly basis to ensure they are functioning properly documenting results on his weekly rounds checklist. The Administrator will monitor for compliance. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated no less than quarterly for effectiveness on a continuing basis.	12/2/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dei Darden, RN, LNHA* TITLE: Administrator (X6) DATE: 12/7/13

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.

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

PRINTED: 11/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2013
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28937		
(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 There were no Life Safety Code Deficiencies noted at time of survey.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Chris Darnoff, RN, LNHA* TITLE Administrator (X6) DATE 12/7/13

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.

DRW