STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/19/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	**625 ASHLAND STREET** **ARCHDALE, NC 27263**

(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 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. In the exit conference all deficiencies noted were discussed with administration. Stories: One Construction Type III (211) Constructed: 1993 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 68 Census - 64 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)	K 052	1) Smoke detector was replaced on	3/11/15

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

Electronically Signed | 03/11/2015

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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	345450	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/19/2015**

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WESTWOOD HEALTH AND REHABILITA	**625 ASHLAND STREET** **ARCHDALE, NC 27263**

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K 052	Continued From page 1 Based on observations on 2/19/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The facility has smoke detector near room 128 that did not activated the fire alarm control system for the facility when tested. Smoke detectors required in the egress corridors must be connected to the fire alarm control panel and must be tested and kept in good working order. This deficiency affected 1 of approximately 5 egress corridors. Ref: 2000 NFPA 101 Section 9.6.3	K 052	2/20/15 near room 128. 2) All smoke detectors were audited to establish 100% compliance. No other smoke detectors were found to be deficient. 3) 10% of smoke detectors in all areas(resident rooms, staff offices, laundry, kitchen, break room, lobby, public bathrooms, and halls will be checked -Weekly x4, the every 2 weeks x 2, then once monthly x 3 months. 4) The Executive Director will report the findings of the monitoring to the QAPI committee monthly x 3 months for review and recommendations.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations on 2/19/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The facility has items stored in the egress corridor.	K 072	1) Items noted to be on C-Hall were removed. 2) Education will be provided for staff related to designated storage areas. 3) Monitoring of halls for inappropriate storage will be completed 5x a week. A designated storage area was identified and designated for storage inside the facility. A request for purchase of outside	3/11/15

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	345450	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/19/2015**

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K 072	Continued From page 2 The facility has items store in the egress corridor were residents are allowed that were not used or moved The deficiency affects 1 of approximately 5 egress corridors in the facility. Ref: 2000 NFPA 101 Section 7.1.10.1	K 072	storage is in the approval process. 4) The Executive Director will report the findings of the monitoring to the QAPI committee monthly x 3 months for review and recommendations.	