STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING **02 - MAIN BUILDING** B. WING ______	**02/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	**4414 WILKINSON BLVD** **GASTONIA, NC 28056**

(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 II (222) Constructed: 1989 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 50 Census - 39 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 029 SS=E	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: 42 CFR 483.70 (a)	K 029	Corrective action for the alleged deficient	2/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/27/2015

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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K 029	Continued From page 1 Based on observations on 2/13/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The facility has a condition in the laundry that will increase the possibility of a fire. The facility has a build up of dust and lint in the upper portion of the combustion chamber of the gas fired dryers in the laundry department making higher risk of fire in the laundry. Ref: 2000 NFPA 101 Section 19.3.5.4	K 029	practice was accomplished by cleaning the lint filter of the dryer on 2/13/2015. To ensure that other areas do not exist, the other areas that are cleaned for lint and dust were cleaned and checked on 2/13/2015. All areas that are cleaned for lint and dust were put on the weekly routine maintenance schedule. A system to ensure compliance the Maintenance Director or designee will monitor dryers weekly for 3 months and ongoing thereafter. To ensure the system is effective, the Maintenance Director or designee will keep routine dryer maintenance on his weekly maintenance log, which will be audited monthly and results presented to the QA&A Committee for review and recommendations on a monthly basis.	
K 067 SS=D	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) The facility has fire dampers that are not in the proper orientation.	K 067	Corrective action for this alleged deficient practice was accomplished by closing the dampers in the DON office and the beauty shop area of shower room #1 on	2/20/15

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	345307	A. BUILDING **02 - MAIN BUILDING** B. WING ______	**02/13/2015**

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K 067	Continued From page 2 The facility has two areas where the fire damper in the rated ceiling have deployed and are in the down position. 1. Director of nurse's office 2. Shower room #1 in the beauty shop area The facility must verify the integrity of the radiation damper fusible links in these two locations. The deficiency affected radiation dampers in 1 of approximately 4 smoke compartments. Ref: 2000 NFPA 101 Sections 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	2/20/2015. To ensure no other areas are affected by this alleged deficient practice, all dampers in the building were checked by the Maintenance Director or designee to ensure they were closed and operating properly on 2/20/2015. A system to ensure future compliance was put in place, which states that the Maintenance Director or designee will monitor the dampers once weekly for four months and once monthly thereafter. To ensure the system remains effective, the monitoring logs will be audited by another manager designated by the administrator and the findings will be presented to the QA&A Committee on a monthly basis.	