

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345397	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
NAME OF PROVIDER OR SUPPLIER SHORELAND HLTH CARE & RETIREME			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	
(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: 1 Construction Type V (111) Constructed: 9/10/1991 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 89 Census - 77 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on February 4, 2015 at	K 025	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	2/20/15

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

TITLE

(X6) DATE

Electronically Signed

03/02/2015

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 025	Continued From page 1 approximately 8:300 AM onward, the following deficiencies were noted: 1) The smoke walls located on the 100, 200, 300 hall, and the smoke wall between the kitchen and dining room have holes and/or penetrations that were not sealed in order to maintain the fire resistance rating of the walls. NFPA 101, 19.3.7.3 NFPA 101, 8.3.6.1 This deficiency affected 5 of approximately 7 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 025	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. K 025 Corrective Action On 2/12/2015 the Maintenance Director completed sealing all holes/penetrations noted in the 100,200,300 and kitchen/dining room smoke walls. This was completed following the recommendations made by the Life Safety Surveyor. Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice Systemic Changes The Maintenance Director sealed all holes/penetrations noted in the 100,200,300 and kitchen/dining room smoke walls. This was completed following the recommendations made by the Life Safety Surveyor. Monitor The Maintenance Director checked all		

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K 025	Continued From page 2	K 025	smoke walls for holes/penetrations and sealed on 2/12/15. The Maintenance Director will check all smoke walls monthly and report to QOL Committee. The Maintenance Director will also check smoke walls after any outside contractor completes work in building		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)</p> <p>Based on observations, on February 4, 2015 at approximately 8:300 AM onward, the following deficiencies were noted: 1) The corridor door to the kitchen located near the side exit door and the kitchen door separating the dining from kitchen located in the rated wall on the left side facing the kitchen from the dining room did not close latch and seal smoke tight. This deficiency affected 2 of 4 kitchen door. Failure to comply with minimum standards as referenced increases the risk of death or injury</p>	K 029	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p>	2/20/15	

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K 029	Continued From page 3 due to fire and/or smoke.	K 029	<p>K 029</p> <p>Corrective Action</p> <p>On 2/4/2015 the Maintenance Director assessed the 2 identified kitchen doors. The Maintenance Director adjusted the door hinge on both doors to ensure they closed and latched to seal smoke tight.</p> <p>Resident Potentially Affected</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Systemic Changes</p> <p>The Maintenance Director adjusted the door hinge on both doors to ensure they closed, latched and sealed smoke tight.</p> <p>Monitor</p> <p>Maintenance Director checked all doors in building on 2/4/2015 to ensure all doors close and latch for smoke tight seal. Maintenance Director will check all doors in building to ensure they close, latch and seal smoke tight on monthly building inspection and report to QOL Committee</p>		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		3/2/15	

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on February 4, 2015 at approximately 8:30 AM onward, the following deficiencies were noted: 1) The Emergency Generator when tested did not crank and transfer load from normal to emergency power in 10 seconds. Time to transfer from normal to emergency connected load was approximately 13 seconds. NFPA 110: 3-4.1 NFPA 99 3-4.1.1.8 This deficiency affected the entire facility. Failure to comply with minimum standards as referenced increases the risk of loss of power.	K 144	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. K 144 Corrective Action On 2/28/2015, Thomas Pridgen with TP2 Power Solutions was able to adjust the stepper motor driver gain to ramp engine speed quicker. When tested it cranked and transferred load from normal to emergency power in under 10 seconds. On 3/2/2015, the generator was tested again with Administrator, Maintenance Director and Thomas Pridgen and generator transferred from normal to emergency in under 10 seconds. Resident Potentially Affected All residents have the potential to be		

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

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K 144	Continued From page 5	K 144	<p>affected by this alleged deficient practice .</p> <p>Systemic Changes</p> <p>The generator has been adjusted to crank and transfer load from normal to emergency power in under 10 seconds</p> <p>Monitor</p> <p>Maintenance Director will test generator weekly and monitor transfer times to ensure they stay under the required 10 seconds. Maintenance Director will report findings to QOL Committee.</p>		