PRINTED: 03/30/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SHORELAND HITH CARE A RETIREME SITURD FLOWER PRIDOEN DRIVE WHITEVILLE, NC 28472 WHITEVILLE, NC 28472 K 000 INITIAL COMMENTS A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 420FR 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: 9701991 Fully Sprinkled - Yee At time of survey the: Certified Best: Medicare/Medicaid - 89 Census - 77 The requirement at 42 CFR, Subpart 483.70(a) is NOTE as evidence by: NFPA 101 LIFE SAFETY CODE STANDARD K 025 SSS= Smoke barriers are constructed to provide at least one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an artism wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartment are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in thilly duced heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 ABSORDATION DIRECTORS OR PROVIDENSUPPLIER REPRESENTATIVES SIGNATURE STREET ADDRESS, CITY, STREET, 2PC 200E 200E 200E 200E 200E 200E 200E 200	1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 11 - Main Building 01	(X3) DATE SURVEY COMPLETED		
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	LABORATORIA	DIDECTORIO CE EDOVITE	OUDDINED DEDDEOCNITATIVE OF COLUMN		TITLE	(VO) DATE		

BORATORY 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345397 B. WING 02/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE SHORELAND HLTH CARE & RETIREME WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 1 K 025 approximately 8:300 AM onward, the following alleged deficiencies. To remain in deficiencies were noted: compliance with all federal and state 1) The smoke walls located on the 100, 200, 300 regulations the facility has taken or will hall, and the smoke wall between the kitchen and take the actions set forth in this plan of dining room have holes and/or penetrations that correction. The plan of correction were not sealed in order to maintain the fire constitutes the facility □s allegation of resistance rating of the walls. compliance such that all alleged NFPA 101, 19.3.7.3 deficiencies cited have been or will be NFPA 101, 8.3.6.1 corrected by the date or dates indicated. This deficiency affected 5 of approximately 7 K 025 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury Corrective Action due to fire and/or smoke. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER ND HLTH CARE & RETII	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472				
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K 025	Continued From page 2		KC	smoke walls for holes/penetra sealed on 2/12/15. The Main Director will check all smoke wanthly and report to QOL Co The Maintenance Director will smoke walls after any outside completes work in building	tenance walls ommittee. I also ched	ck		
K 029 SS=D	One hour fire rated co fire-rated doors) or ar extinguishing system and/or 19.3.5.4 protec the approved automa option is used, the ard other spaces by smol doors. Doors are self	enstruction (with ¾ hour approved automatic fire in accordance with 8.4.1 ets hazardous areas. When tic fire extinguishing system eas are separated from the resisting partitions and fiscosing and non-rated or e plates that do not exceed without the resisting partition of the door are	K	029		2/20/15		
	42 CFR 483.70 (a) Based on observation approximately 8:300 and deficiencies were noted. The corridor door the side exit door and the dining from kitches on the left side facing room did not close lated. This deficiency affects allure to comply with	not met as evidenced by: as, on February 4, 2015 at AM onward, the following ed: to the kitchen located near the kitchen door separating in located in the rated wall the kitchen from the dining ch and seal smoke tight. ed 2 of 4 kitchen door. In minimum standards as the risk of death or injury		The statements made on this correction are not an admission not constitute an agreement valleged deficiencies. To remai compliance with all federal an regulations the facility has tak take the actions set forth in the correction. The plan of correctionstitutes the facility alleg compliance such that all alleg deficiencies cited have been corrected by the date or dates.	on to and ovith the in in ad state sen or will is plan of cition gation of eed or will be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		345397	B. WING			02/05/2015		
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K 144 SS=F	Continued From page 3 due to fire and/or smoke. 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.			029	Corrective Action 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 the closed and latched to seal smoke tight. Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practic. Systemic Changes The Maintenance Director adjusted the door hinge on both doors to ensure the closed, latched and sealed smoke tight. Monitor Maintenance Director checked all doors building on 2/4/2015 to ensure all doors close and latch for smoke tight seal. Maintenance Director will check all door in building to ensure they close, latch a seal smoke tight on monthly building inspection and report to QOL Committee.	e e e e e e e e e e e e e e e e e e e	3/2/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPLE CONSTRUCTION LDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
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K 144	Continued From page	2 4	K 1	44					
	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.			correct not constitute and the composition of the correct constitute and the correct c	statements made on this plan of ction are not an admission to and constitute an agreement with the ed deficiencies. To remain in cliance with all federal and state ations the facility has taken or with the actions set forth in this plan of ction. The plan of correction itutes the facility sallegation of cliance such that all alleged encies cited have been or will be cted by the date or dates indicated at a ctive Action 28/2015, Thomas Pridgen with the motor driver gain to ramp engular department of the cranker ansferred load from normal to gency power in under 10 second with Administrator, Maintenance to and Thomas Pridgen and rator transferred from normal to gency in under 10 seconds. Sent Potentially Affected sidents have the potential to be	II of ed. FP2 e ine d ds.			

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K 144	Continued From page	5	K 1	144	affected by this alleged deficient practice. Systemic Changes The generator has been adjusted to creat and transfer load from normal to emergency power in under 10 seconds. Monitor Maintenance Director will test generate weekly and monitor transfer times to ensure they stay under the required 10 seconds. Maintenance Director will repfindings to QOL Committee.	ank s		