STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	**2001 VANHAVEN DRIVE** **STATESVILLE, NC 28625**

(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: 12/19/2001 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid 103 Census = 103 The LSC deficiencies determined during the survey are as follows:	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 02/09/2015 at approximately 9:00 AM onward, there is a hole in the rated roof/ceiling assembly beside sprinkler - located in resident room 213. The deficiency affected one smoke compartment and potentially the means of egress within smoke compartment.	K 012	The following corrective action has been accomplished for the alleged deficient practice identified in the Life Safety survey of 2/9/15. The hole in the rated roof/ceiling assembly beside the sprinkler was repaired and caulked. For other residents with the potential to be affected by this alleged deficient practice, the following intervention was	3/12/15

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

Electronically Signed | 02/26/2015

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 012	Continued From page 1 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 012	accomplished. 100% walking review of all rooms with focus on housing of sprinklers to ensure there no gaps between sprinklers and ceilings. The following systemic changes have been put in place to ensure that this alleged deficient practice does not recur. The maintenance Supervisor or designee will make walking rounds weekly for 4 weeks to ensure all sprinklers are intact and without ceiling gaps. Then the Maintenance Supervisor or designee will make rounds weekly at random. The Maintenance Supervisor is responsible for monitoring of compliance and reports all identified concerns a the the Quality Assurance Committee Meeting for further follow-up and review as indicated.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 02/09/2015 at approximately 9:00 AM onward, the following deficiencies were noted: 1. Door to kitchen from dining area is held in the open position due to air imbalance caused by range hood exhaust system and make-up air system.	K 069	The following corrective action has been accomplished for the alleged deficient practice regarding the door to the kitchen from the service hall. A private contractor has been retained to take corrective measures as necessary to resolve the issue with the door not closing. Said corrective measure will be in place by March 12, 2015.	3/12/15

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K 069	Continued From page 2 2. Door to kitchen from service hall area is held in the open position due to air imbalance caused by range hood exhaust system and make up air system. These deficiencies affected one of one smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke in the means of egress.	K 069	For other residents with the potential to be affected by the alleged deficient practice, the following intervention has been accomplished. All fire doors were inspected by the Maintenance Supervisor to ensure proper closure. The following systemic changes have been put in place to ensure that this alleged deficient practice does not recur. The Maintenance Supervisor or designee will make walking rounds weekly for 4 weeks to inspect facility doors for concerns. Any discrepancies/concerns will be immediately addressed and corrected. After 4 weeks, the Maintenance Supervisor will make walking rounds weekly at random. The Maintenance Supervisor is responsible for monitoring of compliance and reports all concerns identified at the Quality Assurance Committee Meeting for further follow-up and review as indicated.	