

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

PRINTED: 04/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD SALISBURY, NC 28147</b>		
(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  This 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. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. In the exit conference all deficiencies noted were discussed with administration.  At time of survey the: Total Certified Bed Count = 160 NF Census = 144 NF  The deficiencies determined during the survey are as follows:	K 000			
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		3/21/15	

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

TITLE

(X6) DATE

Electronically Signed

02/20/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD SALISBURY, NC 28147</b>		
(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 018	Continued From page 1  This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)  Based on observations, on February 4, 2015 at approximately 8:00 am onward, the following deficiencies were noted:  1. Positive latching device is not functioning on door to kitchen - located near maintenance office.  2. Door to resident room 101 will not latch in the closed position.  The referenced deficiencies affected two of two smoke compartments, resident rooms, and means of egress within both smoke compartments.  Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 018	1. Smoke doors to entrance of Kitchen and Room 101, have been adjusted to close and operate properly by the Maintenance Director on 2-15-15.  2. Maintenance staff will routinely inspect fire doors to ensure doors work properly, on a daily basis, Monday thru Friday for 30 days.  3. Maintenance Director will inspect all fire doors on a daily basis to make sure door are operating properly on a daily basis, Monday thru Friday for 30 days, weekly for 2 months and monthly as outlined in Preventative Maintenance Program.  4. Maintenance Director will track and trend the results of the inspections. He will report trends and Process Improvement Plans to the Quality Assurance and Process Improvement Committee (QAPI). The QAPI Committee will make recommendations to ensure continued compliance.		
K 029 SS=D	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	K 029		3/21/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD SALISBURY, NC 28147</b>	
(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 029	Continued From page 2 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)  Based on observations, on February 4, 2015 at approximately 8:00 am onward, the following deficiency is noted:  Hole in fire rated wall between B-hall furnace room and resident room 601.  The referenced deficiency affected one of one smoke compartment, resident rooms, and means of egress within smoke compartment.  Failure to comply with minimum standard as referenced increases the risk of death or injury due to fire and/or smoke.  Note: The facility is constructed to comply with the 1985 New Life Safety Code. Sprinkler and one hour enclosure is required under this standard for the referenced area.	K 029	1. As of 2-15-15, the fire rated wall with hole has been repaired by the Maintenance Director by replacing the sheet rock and sealing.  2. As of 2-15-15, all mechanical rooms and fire walls have been inspected by the Maintenance Director to ensure they meet requirements of code.  3. Maintenance Director or designee will inspect fire walls weekly for 30 day and then as outlined in the Preventative Maintenance Program to ensure fire walls are sealed.  4. Maintenance Director will track and trend the results of the inspections and report the trends and Process Improvement Plans to QAPI. The QAPI Committee will review the results and make further recommendations to ensure continued compliance.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		3/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD SALISBURY, NC 28147</b>		
(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 062	Continued From page 3 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)  Based on observations, on February 4, 2015 at approximately 8:00 am onward, the following deficiencies were noted:  1. The new supply closet is not covered by automatic sprinkler - located near front reception desk.  2. There is paint on the heat sensitive element of sprinkler in B-hall dining room.  The referenced deficiencies affected one of one smoke compartment, resident rooms, and means of egress within smoke compartment enclosing identified areas.  Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	1. On 1-15-15, Maintenance Director contacted Simplex to measure, quote and install sprinkler to supply mailbox closet and replace sprinkler head in Side B dining room. Repair will be made by 3-21-15 by contractor.  2. Maintenance Director completed audit on 2-19-15 of sprinkler heads to identify any others in need of repair.  3. Maintenance Director and or designee will inspect sprinkler system to include: sprinkler heads daily, Monday thru Friday for 30 days. Thereafter, they will be inspected monthly as outlined in Preventative Maintenance Program.  4. The Maintenance Director will track and trends the results of the audits. He will report the trends and Process Improvement Plans on a monthly basis to the QAPI Committee. The Committee will make recommendation to ensure continued compliance.		
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	K 072		3/21/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD SALISBURY, NC 28147</b>		
(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 072	<p>Continued From page 4 exits, access to, egress from, or visibility of exits. 7.1.10</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 8:00 am onward, the following deficiencies were noted:</p> <p>1. Two doors to closets protrude greater than seven inches into the corridor in the fully open position. Doors are located in door openings to closets near resident rooms 510 and 512.</p> <p>The referenced deficiencies affected one of one smoke compartment, resident rooms, and means of egress within smoke compartment.</p> <p>Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</p>	K 072	<p>1. Closet doors identified on 500 hall will have self closures installed by 3-21-15 by Maintenance Director or Designee. Door closures order by Maintenance Director on 2-15-15.</p> <p>2. On 2-15-15, The Maintenance Director audited facility to identify other doors that need closures.</p> <p>3. Maintenance Director will Audit facility on a weekly basis for 30 days to ensure operation and function of doors.</p> <p>4. The Maintenance Director will track and trend the results of the audit and report to the QAPI Committee the results of the trends and Process Improvement Plans. The QAPI Committee will make recommendations to ensure continued compliance.</p>		