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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/25/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	**POST OFFICE BOX 1940** **SMITHFIELD, NC 27577**

(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 II (222) 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 +20 HA=180 Census =154 NF + 0 HA=154 The deficiencies determined during the survey are as follows:	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 2/25/15 at approximately 11 AM onward, the following	K 022	"No Exit" signs as per regulated specifications placed in Garden Room, Employee Lounge, North Wing, and Main Lobby on March 2, 2015, by Director of	3/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2015

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 022	Continued From page 1 deficiencies were noted: The means of egress was non-compliant, specific findings include: The doors from inside the Garden Room to the enclosed exterior courtyard did not have a sign reading "NO EXIT". The doors have glass vision panels and appeared to lead to the exterior of the building; therefore it could be mistaken for an exit. Ref: 2000 NFPA 101 Sections 18.2.10, 10.8.1 Any door that is likely to be mistaken for an exit shall be identified by a sign reading "NO EXIT". Such sign shall have the word NO in letters 2" high with a stroke width of 3/8" and the EXIT in letters 1" high, with the word EXIT below the word NO. This deficiency affected one of eight smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 022	Environmental Services. Entire facility canvassed by the Director of Environmental Services on 02/27/15 to ascertain that any door that is likely to be mistaken for an exit is identified by a sign reading "No Exit". In-service conducted for Department Heads and Environmental Services staff by the Director of Environmental Services by 03/12/2015 to include; but, not limited to, ensuring that all doors that may be likely mistaken for an exit are identified by a sign reading "No Exit" as per specifications. Quarterly audits to be performed by the Director of Environmental Services to ensure that all doors that are likely to be mistaken for an exit are identified by a sign reading "No Exit". These audits will be included in the agenda of the Quarterly Quality Assurance Committee for the review by its membership and monitoring of the facility's compliance with this requirement.	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 2/25/15 at approximately 11 AM onward, the following	K 070	Space heater removed form Staff Development office on 02/25/2015 by Director of Environmental Services. Entire facility canvassed by Director of	3/12/15

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K 070	Continued From page 2 deficiencies were noted: There was a portable space heater in use near room 228 inside the staff development infection control office Ref: 2000 NFPA 101 Section 19.7.8 Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degree F (100 degrees C) This deficiency affected one of eight smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 070	Environmental Services to ascertain the absence of space heaters in use in the facility. In-service conducted by Director of Environmental Services by 03/12/2015 to Department Heads and Environmental Service staff to include; but, not limited to, facility policy implemented to prohibit the use of space heaters throughout the entire facility. Audit to be performed quarterly by Director of Environmental Services to ascertain the absence of space heaters in the facility. These audit to be included under the Safety Agenda of the quarterly Quality Assurance Committee for its membership's review and monitoring of the facility's compliance.	