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
	345463	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/25/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	**400 THOMPSON STREET** **HENDERSONVILLE, NC 28792**

(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 = 80 NF Census = 66 NF The deficiencies determined during the survey are as follows:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 02/25/2015 at approximately 8:30 AM onward, the following deficiencies were noted: One of two smoke barrier door leafs would not open properly due to damaged automatic flush bolts mounted to face of door from the egress side, The smoke barrier door is located near the	K 038	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and executed because it is required by provisions of Federal and State regulations. A. The damaged automatic flush bolts mounted to the face of the smoke barrier	3/6/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2015

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 038	Continued From page 1 central supply room - on main front entrance corridor. This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	door on the main corridor were repaired on 2/27/15. B. All smoke barrier doors were inspected on 2/25/15 to ensure exits are readily accessible at all times. C. The Maintenance Director and/or his designee will conduct weekly inspections of all smoke barrier doors to ensure compliance. D. The Quality Assurance Performance Improvement Committee will review for compliance monthly times four months.	
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 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 02/25/2015 at approximately 10::00 AM onward, the following deficiencies were noted: The wall-mounted clerical pad protrudes, much greater than permitted, into required corridor width in the fully open position - the pad did not self-close when opened and released. Pad is located on corridor wall between rooms 503 and 504.	K 072	A. The wall-mounted clerical pad located on the 500 hall corridor was repaired on 2/27/15 to ensure that it would self close when opened and released. B. All wall-mounted clerical pads were inspected on 2/25/15 to ensure that they self closed when opened and released. C. The Maintenance Director and/or his designee will conduct weekly inspections of all wall-mounted clerical pads to ensure compliance. D. The Quality Assurance Performance Improvement Committee wil review for	3/6/15

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K 072	Continued From page 2 This deficiency affected one of approximately six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 072	compliance monthly times four months.	