STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	**2461 LEGION ROAD** **FAYETTEVILLE, NC 28306**

(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. Facility is using special locking. Stories: one Construction Type V Constructed: 1990 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 120 Census - 104 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 03/19/2015 at	K 027	Fire Doors on 200 Hall near room 241 that would not fully close were identified	4/2/15

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

Electronically Signed | 04/07/2015

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K 027	Continued From page 1 approximately 8:30 AM onward, the following deficiencies were noted: smoke doors in smoke barrier on 200 hall by rooms 241 and 242 did not close an latch for smoke tight seal. NFPA 101, 19.2.2.2.6 This deficiency affected one of 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 027	and John Combs and David Letchworth were notified on 3-20-2015 to come out and correct. Fire doors were repaired 4-2-2015 by John and David. All other Fire Doors throughout the facility were audited to assure proper closure and latch for smoke tight seal on 3-20-15 by Maintenance Assistant. Any door identified as not presenting as a smoke tight fire door was repaired by John Combs and David Letchworth on 4-2-2014. The facility maintenance director will audit the facility doors for appropriate closure mechanisms weekly for four weeks then monthly for 3 months to assure all doors close properly. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on assuring the Fire Doors are in good repair and close appropriately. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		3/20/15

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K 029	Continued From page 2 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 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 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: soild linen door on 200 hall was not positive latching at time of survey. NFPA 101, 19.3.5.4 NFPA 101, 8.4.1 This deficiency affected one of 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 029	The Door to 200 Hall Soiled Linen room was repaired to be self-close on 3/20/2015 by the Maintenance Assistant. All other doors throughout the facility were audited to assure had appropriate closure mechanisms on 3-20-15 by Maintenance Assistant. Any door identified was repaired on 3-20-2015. The facility maintenance director will audit the facility doors for appropriate closure mechanisms weekly for four weeks then monthly for 3 months to assure all doors are in good repair and close properly. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on assuring the doors are in good repair and close appropriately. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any	

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K 029	Continued From page 3	K 029	identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as necessary.	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: 1. facility could not provide proper documentation that the fire alarm system had a yearly inspection. 2. facility could not provide proper documentation that a sensitivity test on smoke detectors had ben performed in a 2 years. NFPA 101, 19.3.4 NFPA 101. 9.6 NFPA 72	K 052	Upon being made aware of lack of documentation pertaining to 1. Fire alarm system annually inspected. 2. Sensitivity tests on smoke detectors performed every 2 years, the Maintenance Assistant notified BFPE to schedule tests. Tests for alarm system and sensitivity were completed by Tim Brian with BFPE on 3-30-2015. This documentation is essential for the safety of all residents. Maintenance Assistant audited documentation of these	3/30/15

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K 052	Continued From page 4 This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 052	records and similar records to ensure they were on file on 3-20-2015. Any findings were corrected on 3-20-2015 by Maintenance Assistant. The facility maintenance director will audit the facility to ensure documentation is kept in a 3 ring binder for easy retrieval weekly for four weeks then monthly for 3 months. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on the importance of keeping documentation on file in an organized 3 ring binder. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issue will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating 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 03/19/2015 at	K 062	Sprinkler head in kitchen that did not have escutcheon was corrected on	3/20/15

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K 062	Continued From page 5 approximately 8:30 AM onward, the following deficiencies were noted: 1. escutcheon cover was missing from sprinkler head in kitchen area. 2. boxes stored within 18 inches of sprinkler head in cooler and freezer in kitchen. NFPA 101, 19.7.6 NFPA 25 NFPA 13 This deficiency affected only kitchen . Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	3/20/2015 by Maintenance Assistant. The space located in the walk-in cooler and walk-in freezer has been corrected by Maintenance Assistant as of 3-20-2015 to ensure clearance for the sprinkler heads in the amount of 18 from sprinkler head. Facility audit to ensure all sprinkler heads have escutcheon piece and audit to ensure 18 clearance for sprinkler heads was completed on 3-20-15 by Maintenance Assistant. Any areas identified were corrected by Assistant Director of Maintenance on 3-20-2015. The facility maintenance director will audit the facility sprinkler heads for escutcheon and also clearance of 18 weekly for four weeks then monthly for 3 months to assure all doors are in good repair and close properly. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on sprinkler head escutcheon as well as 18 clearance for all sprinkler heads. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation and corrections as indicated.	
K 069	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		3/20/15

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K 069 SS=E	Continued From page 6 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 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: facility could not provide proper documentation on hood system being inspected in six months. NFPA 101, 19.3.2.6 NFPA 96 This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 069	Upon being made aware of lack of documentation for the Annual Kitchen Hood Inspection, Administrator was able to locate the inspection document on 3-20-2015. This inspection was complete November 2014. This documentation is essential to ensure the safety of all residents. Maintenance Assistant audited documentation of these records and similar records to ensure they were on file on 3-20-2015. Any findings were corrected on 3-20-2015 by Maintenance Assistant. The facility maintenance director will audit the facility to ensure documentation is kept in a 3 ring binder for easy retrieval weekly for four weeks then monthly for 3 months. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on importance of keeping documentation on file in an organized 3 ring binder. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issue will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further	

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K 069	Continued From page 7	K 069	recommendation or corrections as indicated.	
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 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: electric wheelchair, hoyer lift and scale was stored on corridor exit by Dining room. NFPA 101, 7.1.10 This deficiency affected one of 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	Electric Wheelchair, Hoyer Lift, along with Scale was removed from corridor exit near dining room on 3-20-15 by Maintenance Assistant to ensure means of egress are free from obstructions or impediments. Facility audit to ensure facility means of egress are free from any obstructions or impediment was completed on 3-20-2015 by Maintenance Assistant. Any areas identified were corrected by Maintenance Assistant on 3-20-2015. The facility maintenance director will audit the facility to ensure facility means of egress are free from obstructions or impediments weekly for four weeks then monthly for 3 months. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on the importance of keeping hallways / means of egress free from any obstructions or	3/20/15

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K 072	Continued From page 8	K 072	impediments. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.	
K 144 SS=E	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. This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 03/19/2015 at approximately 8:30 AM onward, the following deficiencies were noted: facility could not provide proper documentation that generator is being run under load for 30 minutes monthly. NFPA 99, 3.4.4.1 NFPA 110, 8.4.2	K 144	Upon being made aware of annual documentation pertaining to generator tests being conducted monthly for 30 min on a full load, Administrator was able to confirm the documentation was on file at corporate main office 3-20-2015. Administrator also conducted load test as well on 3-20-15. This documentation is essential to ensure the safety of all residents. Maintenance	3/20/15

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K 144	Continued From page 9 This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144	Assistant audited documentation of these records and similar records to ensure they were on file on 3-20-2015. Any findings were corrected on 3-20-2015 by Maintenance Assistant. The facility maintenance director will audit the facility to ensure documentation is kept in a 3 ring binder for easy retrieval weekly for four weeks then monthly for 3 months. The Director of Maintenance and maintenance assistant were re-educated by the Administrator on 3-24-2015 on importance of keeping documentation on file in an organized 3 ring binder. The results of the audits will be reviewed with the Administrator weekly for further recommendations as indicated. Any identified issues will be corrected upon identification and reviewed with the Administrator. The Administrator will review the audits with monthly Executive Quality Assurance Committee for further recommendation or corrections as indicated.	