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
	345045	A. BUILDING **01 - MAIN BUILDING (1ST/2ND FLR)** B. WING ______	**04/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK REHAB DAVANT EXTENDED CARE CTR	**418 CHESTNUT STREET** **BLOWING ROCK, NC 28605**

(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, three stories, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed with administration. At time of survey the: Total Certified Bed Count = 72 Census = 59 The deficiencies determined during the survey are as follows:	K 000		
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 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 4/22/2015 at	K 029	The door located beside the lower level west wing has been repaired and completed on 04/27/15 with positive	4/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2015

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 029	Continued From page 1 approximately 11:30 AM onward, the following deficiencies were noted: This standard is non-compliant, specific findings include: There is no positive latching hardware on storage room door located beside lower level west exit discharge - near loading dock. 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 029	latching hardware. Review of similar areas in the building by the Director of Maintenance revealed no further issues and no Residents were affected. A monthly audit of all doors will be conducted with the monthly facility Fire Drill and ongoing by the Maintenance Director/designee. To ensure continued compliance, the Director of Maintenance/designee will repair any issues found and review these items monthly and report any patterns/trends and changes to the monthly Facility monthly Quality Assurance committee and to the quarterly Performance Improvement Committee.	
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 4/22/2015 at approximately 11:30 AM onward, the following deficiencies were noted: This standard is non-compliant, specific findings include: There is no guardrail provided at loading dock beyond exit discharge - serving lower level west	K 032	The guardrail at the loading dock beyond exit discharge serving the lower level west wing and activity area had quotes provided on 04/23/15 to be installed on 05/12/15. Review and audit of similar areas by the Maintenance Director revealed no other areas required a guardrail. The loading dock will be monitored weekly	5/12/15

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K 032	Continued From page 2 wing and activity area. 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 032	X 4 weeks and then monthly X 4 months by the Maintenance Director/designee. To ensure continued compliance, the Director of Maintenance/designee will review these items monthly and report patterns/trends and changes to the monthly Facility Quality Assurance program and to the quarterly Performance Improvement Committee.	
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 4/22/2015 at approximately 11:30 AM onward, the following deficiencies were noted: This standard is non-compliant, specific findings include: Sprinkler piping at base of exit stairway protrudes into six feet and eight inch headroom clearance of egress path. This deficiency affected three of three smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury	K 072	The sprinkler piping at the base of the stairway was relocated to allow clearance of the egress path on 05/20/15. A Review of similar areas in the building by the Director of Maintenance revealed no further issues and no Residents were affected. A daily audit will be performed by the Maintenance Director/designee to ensure no furnishing, decorations, or other objects obstruct exits, access to, egress from, or visibility of the exits. To ensure continued compliance, the Director of Maintenance/designee will repair any issues found and review these items monthly reporting any	5/20/15

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K 072	Continued From page 3 due to fire and/or smoke.	K 072	patterns/trends and changes to the Facility monthly Quality Assurance committee and to the quarterly Performance Improvement Committee.	
K 146 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 4/22/2015 at approximately 11:30 AM onward, the following deficiencies were noted: This standard is non-compliant, specific findings include: 1. The generator annunciator panel did not read emergency power system supplying load with the emergency power system in emergency mode. 2. The essential electrical system did not energize required emergency lighting in corridor area in front of first floor nurse's station - located beyond front entrance lobby. 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 146	The generator annunciator panel was repaired to read when the emergency supply power system was supplying load with emergency power in the emergency mode on 05/06/15. The emergency lighting in the corridor in front of the nurse□s station located beyond the front entrance lobby was repaired to be energized by the generator on 05/06/15. A review of similar areas in the building by the Director of Maintenance revealed no further issues and no Residents were affected. The monthly partial load generator test performed by the Maintenance Director/designee will audit for the emergency lighting and the generator readings on the enunciator panel. The Maintenance Director will audit for emergency lights and the generator readings on the enunciator panel with the	5/6/15

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K 146	Continued From page 4	K 146	annual Full Load preventative maintenance generator test. To ensure continued compliance, the Director of Maintenance/designee will repair any issues found and review these items monthly and report any patterns /trends and changes to the monthly Facility Quality Assurance program and the quarterly Performance Improvement committee.	